

**KINGSBOROUGH COMMUNITY COLLEGE
OF THE
CITY UNIVERSITY OF NEW YORK
MEDICAL RECORD**

Day
Evening
Transfer

This information is requested voluntarily. Student's medical records are confidential and are kept under secure conditions. They are used only by authorized personnel for the purpose of furnishing counseling service and assistance.

Sex
M
F

STUDENT'S

NAME _____
Last First Middle Former

ADDRESS _____
No. Street City State Zip Code

HOME TELEPHONE NO: _____ DATE OF BIRTH _____ SOC. SEC. NO. _____

PARENT'S NAME _____

IN CASE OF EMERGENCY NOTIFY: _____ PHONE: _____

APPLICANT'S SIGNATURE _____ ENTERING SPRING FALL 20 _____

ALLOCATED TO _____ SCHOOL LAST ATTENDED _____

PERSONAL HISTORY

CHECK CONDITION(S) THAT YOU HAVE AND DESCRIBE BELOW:

CONDITION	YES	NO	CONDITION	YES	NO
ALLERGIES			HEART		
ASTHMA			INJURIES		
CANCER, CYSTS, TUMOR, ETC.			KIDNEY		
CONVULSIONS OR EPILEPSY			MUSCULO-SKELETAL		
DIABETES			NERVOUS		
DRUG HABIT			RHEUMATIC FEVER		
EARS			THYROID		
EYES			TUBERCULOSIS		
FAINING			VENEREAL DISEASE		
GASTRO-INTESTINAL					

1. DESCRIBE ANY ITEM CHECKED YES: _____

2. LIST ALL PREVIOUS SERIOUS ILLNESSES AND/OR OPERATIONS: _____

DATE _____

CHECK BOX OF ANY PHYSICAL HANDICAP:

- A. WHEELCHAIR BOUND
- B. BLIND OR PARTIALLY SIGHTED
- C. USE BRACES AND CRUTCHES
- E. NEUROLOGICAL IMPAIRMENTS (POLIO, CEREBRAL PALSY, ETC.)
- F. SPEECH IMPEDIMENTS
- G. OTHER - IDENTIFY: _____

BRIEFLY DESCRIBE DISABILITY: _____

PHYSICAL EXAMINATION

(TO BE COMPLETED BY A LICENSED PHYSICIAN)

TUBERCULIN PPD

HEIGHT ___ IN. WEIGHT ___ LBS. VISION O.D. ___ CORR. ___ (MANTOUX TEST) DATE ___ RESULT ___

O.S. ___ CORR. ___ CHEST XRAY: DATE: ___ RESULT ___
Month Year

B.P. ___ / ___ mmHg. PULSE ___ /min.

Hgb. ___ Gm.% URINE ANALYSIS: PROTEIN ___ GLUCOSE ___

NORMAL	ABNORMAL		REMARKS – DESCRIBE ABNORMALITIES ONLY
		HEAD & NECK	
		NOSE AND SINUSES	
		MOUTH AND THROAT	
		GUMS AND TEETH	
		EYES	
		EARS, HEARNG	
		CHEST, BREASTS, LUNGS	
		HEART	
		VASCULAR SYSTEM	
		ABDOMEN AND VISCERA	
		HERNIA	
		ANUS AND RECTUM	
		GENITO-URINARY SYSTEM	
		ENDOCRINE SYSTEM	
		SPINE AND MUSCULOSKELETAL	
		SKIN-IDENTIFYING MARKS, SCARS, TATTOOS	
		NEUROLOGIC	
		PSYCHIATRIC	

IS THERE ANY EMOTIONAL, MENTAL OR PHYSICAL CONDITION FOR WHICH THIS STUDENT IS UNDER MEDICAL OBSERVATION AND/OR TAKING MEDICATION: YES NO
SPECIFY:

PHYSICIAN'S NAME (print or type) _____

SIGNATURE _____ PHONE NO. _____

ADDRESS _____

DATE OF EXAMINATION: _____

ATTENTION NURSING STUDENTS:

Pursuant to section 405.3 (b) of the New York State Hospital Codes, the following Statements of Physical Examination is required:

I have examined _____ on date _____

(Student's Name)

Based on my physical examination and the patient's medical history, I believe that the above-referenced person is free from a health impairment that is of potential risk to patients or that might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances known to alter a person's behavior.

Physician's Signature

License Number