REVIEW OF SYSTEMS TO BE COMPLETED BY HEALTH CARE PROVIDER (other than parent)
(All “yes” answers must be fully explained below.)

Ears, Eyes, Nose, Throat
- Yes  No  1. Eye Problems (blurred vision, infection, double vision, etc.)
- Yes  No  2. Ear Infections
- Yes  No  3. Decreased Hearing Acuity
- Yes  No  4. Sinus Infections
- Yes  No  5. Frequent Sore Throats
- Yes  No  6. Mouth Ulcer

Cardiac
- Yes  No  7. Murmurs
- Yes  No  8. Palpitations
- Yes  No  9. Chest Pain
- Yes  No  10. High Blood Pressure
- Yes  No  11. Other Heart Disease

Respiratory
- Yes  No  12. Wheezes-Asthma
- Yes  No  13. Frequent Colds
- Yes  No  14. Chronic Cough
- Yes  No  15. Treatment for Tuberculosis
- Yes  No  16. Exposure to Tuberculosis
- Yes  No  17. Smoker
- Yes  No  18. Pneumonia

Gastrointestinal
- Yes  No  19. Indigestion
- Yes  No  20. Hemorrhoids
- Yes  No  21. Gallbladder Disease
- Yes  No  22. Constipation
- Yes  No  23. Diarrhea
- Yes  No  24. Rectal Bleeding
- Yes  No  25. Recurrent Abdominal Pain
- Yes  No  26. Gastroesophageal Reflux
- Yes  No  27. Celiac Disease

Genito-Urinary
- Yes  No  28. Kidney Disease
- Yes  No  29. Recurrent Urinary Tract Infection
- Yes  No  30. Painful Urination
- Yes  No  31. Kidney Stones
- Yes  No  32. Irregular Menses
- Yes  No  33. Dysmenorrhea

Neuro-psychologic
- Yes  No  34. Headaches
- Yes  No  35. Concussion
- Yes  No  36. Seizures
- Yes  No  37. Paresthesias
- Yes  No  38. Sensory Loss
- Yes  No  39. Weakness
- Yes  No  40. Mood Disorder
- Yes  No  41. Eating Disorder
- Yes  No  42. Sleeping Disorder
- Yes  No  43. Anxiety
- Yes  No  44. Depression

Musculoskeletal
- Yes  No  45. Joint Problems
- Yes  No  46. Back Problems
- Yes  No  47. Neck or Spinal Injury
- Yes  No  48. Tendonitis or Bursitis

Other
- Yes  No  49. Diabetes
- Yes  No  50. History of Malaria
- Yes  No  51. Cancer
- Yes  No  52. Other Chronic Disease or Disability

Other Significant Health Problems:

Explanation for all positive responses: (please refer to numbers above)

Allergies

Current Medications/Dietary Restrictions

Hospitalizations
Student Name __________________________  Last Name __________________________  First Name __________________________  DOB __________________________

TO BE COMPLETED BY HEALTH CARE PROVIDER (OTHER THAN PARENT).

Physician Examination  Date: __________________________

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<tr>
<th>Height (inches)</th>
<th>Weight (pounds)</th>
<th>BMI</th>
<th>Blood Pressure</th>
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Visual Acuity:  with correction __________________________  left  right
                 without correction __________________________  left  right

Check if normal or abnormal

- Normal  Abnormal
- Normal  Abnormal
- Normal  Abnormal
- Normal  Abnormal
- Normal  Abnormal
- Normal  Abnormal
- Normal  Abnormal
- Normal  Abnormal
- Normal  Abnormal
- Normal  Abnormal

Summary of significant findings in history or physical exam:

How long have you known this patient? __________________________

Has this patient ever had any restrictions as to the kind or amount of exercise the patient may take?
- No  Yes  Please explain: __________________________

Is it advisable that this restriction be continued?
- No  Yes  Please explain: __________________________

Has patient ever had a major emotional problem or demonstrated abnormal behavior, of which we should be aware?
- No  Yes  If yes, please describe: __________________________

I have reviewed the history and examined this patient and find the patient physically fit to attend college and participate in all physical activities:
- Yes  No

- Yes, with the following exceptions: __________________________

Name __________________________  M.D./D.O. __________________________  Signed __________________________  M.D./D.O. __________________________

Address __________________________  Telephone __________________________

Page 2 (last updated 3/2019)
Student Name

Last Name First Name DOB MM/DD/YYYY

Student MUST enter these vaccine dates online via the Patient Portal (https://brynmawr.medicatconnet/login.aspx).

**REQUIRED** for international students from countries where hepatitis a is endemic (all countries except USA, Canada, Western Europe, Australia, and Japan)

- Hepatitis A #1__/__/____ MM DD YYYY
- Hepatitis A #2__/__/____ MM DD YYYY

**REQUIRED**

- Hepatitis B #1__/__/____ MM DD YYYY
- Hepatitis B #2__/__/____ MM DD YYYY
- Hepatitis B #3__/__/____ MM DD YYYY
- Varicella #1__/__/____ MM DD YYYY
- Varicella #2__/__/____ MM DD YYYY

If history of illness, titer required:

- Reactive _________ Non Reactive __________

- Measles, Mumps, Rubella #1__/__/____ MM DD YYYY
- Measles, Mumps, Rubella #2__/__/____ MM DD YYYY
- Tetanus, Diptheria, Pertussis (Tdap)__/__/____ (within the last 10 years) MM DD YYYY
- Meningitis Group A__/__/____ MM DD YYYY

**RECOMMENDED**

- HPV #1__/__/____ MM DD YYYY
- HPV #2__/__/____ MM DD YYYY
- HPV #3__/__/____ MM DD YYYY
- Pneumococcal polysaccharide__/__/____ MM DD YYYY
- Meningitis Group B #1__/__/____ MM DD YYYY
- Meningitis Group B #2__/__/____ MM DD YYYY

**IN THE EVENT** of an outbreak of a vaccine preventable disease, students who have not received full immunization will be required to be separated from campus at their own expense.

Students will not be placed in housing until all health records and immunization forms are completed and submitted to the Student Health Center by July 1.

Provider: Please attach a copy of the patient’s immunization record.