## Review of Systems

(All “yes” answers must be fully explained below.)

<table>
<thead>
<tr>
<th>Ears, Eyes, Nose, Throat</th>
<th>Gastrointestinal</th>
<th>Neuro-psychologic</th>
<th>Musculoskeletal</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>1. Eye Problems (blurred vision, infection, double vision, etc.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>2. Ear Infections</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>3. Decreased Hearing Acuity</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>4. Sinus Infections</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>5. Frequent Sore Throats</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>6. Mouth Ulcer</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>7. Murmurs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>8. Palpitations</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>9. Chest Pain</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>10. High Blood Pressure</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>11. Other Heart Disease</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

| Cardiac | Genito - Urinary | | |
| Yes | No | 12. Wheezes-Asthma | Yes | No | 28. Kidney Disease | Yes | No | 45. Back Problems |
| Yes | No | 13. Frequent Colds | Yes | No | 29. Recurrent Urinary Tract Infection | Yes | No | 46. Neck or Spinal Injury |
| Yes | No | 14. Chronic Cough | Yes | No | 30. Painful Urination | Yes | No | 47. Tendonitis or Bursitis |
| Yes | No | 15. Treatment for Tuberculosis | Yes | No | 31. Kidney Stones | Yes | No | 48. Diabetes |
| Yes | No | 16. Exposure to Tuberculosis | Yes | No | 32. Irregular Menses | Yes | No | 49. History of Malaria |
| Yes | No | 17. Smoker | Yes | No | 33. Dysmenorrhea | Yes | No | 50. Cancer |
| Yes | No | 18. Pneumonia | Yes | No | 51. 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
To be completed by health care provider (other than parent).

**Physician Examination**  Date: ________________

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Weight (pounds)</th>
<th>BMI</th>
<th>Blood Pressure</th>
<th>Pulse</th>
<th>Resp</th>
</tr>
</thead>
</table>

**Visual Acuity:** with correction ________________ without correction ________________

left  right  left  right

**Labwork REQUIRED**

Hemoglobin or Hematocrit (within the last 12 months):  Hgb ________________  Hct ________________

**Check if normal or abnormal**

- [ ] Normal  [ ] Abnormal  1. Nutrition
- [ ] Normal  [ ] Abnormal  2. Development
- [ ] Normal  [ ] Abnormal  3. Skin
- [ ] Normal  [ ] Abnormal  4. Eyes/Vision
- [ ] Normal  [ ] Abnormal  5. Ears/Hearing
- [ ] Normal  [ ] Abnormal  6. Nose/Sinuses
- [ ] Normal  [ ] Abnormal  7. Mouth/Throat
- [ ] Normal  [ ] Abnormal  8. Teeth/Gum
- [ ] Normal  [ ] Abnormal  9. Neck/Thyroid
- [ ] Normal  [ ] Abnormal  10. Lymph Glands
- [ ] Normal  [ ] Abnormal  11. Thorax/Breasts
- [ ] Normal  [ ] Abnormal  12. Lungs
- [ ] Normal  [ ] Abnormal  13. Heart/Cardiovascular
- [ ] Normal  [ ] Abnormal  14. Abdomen (Hernia)
- [ ] Normal  [ ] Abnormal  15. Back
- [ ] Normal  [ ] Abnormal  16. Musculoskeletal System
- [ ] Normal  [ ] Abnormal  17. Neurological System
- [ ] Normal  [ ] Abnormal  18. Deep Tendon Reflexes
- [ ] Normal  [ ] Abnormal  19. Personality/Emotional

**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.  **Address**  **Telephone**

Signed  M.D./D.O.
Student Name ___________________________ Last Name ___________________________ First Name ___________________________ DOB ____________

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

REQUIRED

Hepatitis B #1 __/__/____
    MM DD YYYY
Hepatitis B #2 __/__/____
    MM DD YYYY
Hepatitis B #3 __/__/____
    MM DD YYYY
Measles, Mumps, Rubella #1 __/__/____
    MM DD YYYY
Measles, Mumps, Rubella #2 __/__/____
    MM DD YYYY
Measles, Mumps, Rubella #3 __/__/____
    MM DD YYYY
Tetanus, Diphtheria, Pertussis (Tdap) __/__/____
    (within the last 7 years) MM DD YYYY

Meningitis Vaccine or Waiver:
Required to get vaccine or patient must sign waiver below.

Date of vaccine __/__/____
    MM DD YYYY

I have read and understand the information about meningitis on page 4 and I decline the meningitis vaccine at this time. I understand that if I decide in the future that I want the vaccine, I can receive it at the Health Center and be billed.

Print Name ________________________________________________________________

Signature of Student __________________________________________________________

Tuberculosis testing:
All students must have a PPD, a quantiferon gold blood test or chest xray between September 1, 2016, and September 1, 2017.
If the PPD or quantiferon gold blood test is positive, the student must have a chest X-Ray:

PPD Date __/__/____
    MM DD YYYY
Results: □ Negative □ Positive

Quantiferon Gold Date __/__/____
    MM DD YYYY
Results: □ Negative □ Positive

Chest X-Ray Date __/__/____
    MM DD YYYY
Results: □ Negative □ Positive

REQUIRED for international students from all countries except USA, Canada, Western Europe, Australia, and Japan.

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

RECOMMENDED

HPV #1 __/__/____
    MM DD YYYY
HPV #2 __/__/____
    MM DD YYYY
HPV #3 __/__/____
    MM DD YYYY
Pneumococcal polysaccharide __/__/____
    MM DD YYYY
Varicella #1 __/__/____
    MM DD YYYY
Varicella #2 __/__/____
    MM DD YYYY
Varicella disease __/__/____
    MM DD YYYY

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

Meningitis is a rare but potentially fatal infection which can be caused by a virus or bacteria. Permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure, or death can result from the infection. Research indicates that college students, particularly freshmen who live in dormitories or residence halls, have a six-fold increased risk of the disease. There is a vaccine available to protect against the bacterial form of the disease which is 85% to 100% effective in preventing four of the five common bacterial forms of meningitis which cause about 70% of disease in the United States. To date, the vaccine has proven to be safer, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. Immunity generally develops within seven to 10 days and remains effective for approximately three to five years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

The decision of whether or not to receive the meningitis vaccine is a personal one. The American College Health Association and the Advisory Committee on Immunization Practices of the CDC recommend that college students, particularly freshmen, be educated about the disease and the potential benefits of vaccination. We urge you to discuss the question of having the vaccine with your physician and your parents.

In July 2002, the Pennsylvania Legislature passed a law requiring students who live in dormitories to either get the vaccine or sign a waiver indicating you have received information about the disease and the vaccine but opted not to get it. In order to comply with this law you are therefore REQUIRED to get the vaccine or sign the waiver on the Health Service Form. If you have questions, please call before May 17 or email your questions to sheimann@brynmawr.edu.