BRYN MAWR COLLEGE

STUDENT HEALTH FORM

Check one box if not an undergraaduate:
❑ Post Bacc ❑ GSSW ❑ GSAS

Student Name ______________________________ **DOB** ______________
Last Name First Name MM/DD/YYYY

Student MUST upload all completed forms online via the Patient Portal (https://brynmawr.medicatconnect.com/) by July 1.

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

next>>>

Student Name ______________________________ **DOB** ______________

Last Name First Name MM/DD/YYYY

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

Physician Examination Date: ____________

Height (inches)	Weight (pounds)	BMI	Blood Pressure	Pulse	Resp

Visual Acuity: with correction ______________ without correction ______________

left right left right

Check if normal or abnormal

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

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 physcially 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 Date

next>>>

Student Name ______________________________________ **DOB** ______________

Last Name First Name MM/DD/YYYY

Student MUST enter these vaccine dates online via the Patient Portal (https://brynmawr.medicatconnect.com/).

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

Meningitis Group B #1 __/__/____
MM DD YYYY

Meningitis Group B #2 __/__/____
MM DD YYYY

Polio Series __/__/____
Completed: MM DD YYYY

RECOMMENDED

HPV #1 __/__/____
MM DD YYYY

HPV #2 __/__/____
MM DD YYYY

HPV #3 __/__/____
MM DD YYYY

Pneumococcal polysaccharide __/__/____
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.

To the best of my knowledge this information is accurate.

____

Clinician's Signature Date

All students must complete the Tuberculosis screening questionnaire on the next page.

next>>>

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

Bryn Mawr College Health Center Tuberculosis Screening Questionnaire

Student Name ____ **DOB** __________________
Last Name First Name MM/DD/YYYY

Tuberculosis screening questionnaire must be completed by all students within 6 months of matriculation.

If answer yes to any questions, or you are an international student, a blood test is required within 6 months of matriculation and results reported below.

All incoming Bryn Mawr College students, regardless of your answers to the questionnaire, must have had a PPD placed within 6 months of matriculation and results reported below – except for those requiring a TB blood test.

Student MUST upload this completed form on-line via the Patient Portal (https://brynmawr.medicatconnet/login.aspx) by July 1.

Part 1: Screening questionnaire to be completed by student

Have you had close contact with persons known or suspected to have TB disease? ❑ Yes ❑ No

Were you born in, or have ever lived, worked, or visited for more than one month in any of the following: Asia, Africa, South America, Central America or Eastern Europe? ❑ Yes ❑ No
If yes, where? How long?

Have you been a resident and/or employee of high-risk congregate settings (correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at risk for active TB disease? ❑ Yes ❑ No

Have you been a member of any of the following groups that may have increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

Part 2: Clinical Assessment by Health Care Provider

History of positive TB skin test or IGRA blood test? If yes, document below. ❑ Yes ❑ No

History of BCG vaccine? (If yes, consider IGRA if possible.) ❑ Yes ❑ No

Does the student have signs of active TB, such as cough lasting longer than three weeks, coughing up blood, chest pain, loss of appetite, unexplained weight loss, night sweats, fevers? ❑ Yes ❑ No

If yes, proceed with additional evaluation to exclude active TB.

Tuberculin Skin Test (TST)

Date given: ___/___/___ Date read: ___/___/___ Result: ___mm induration Interpretation:___positive ___negative

Interferon Gamma Release Assay (IGRA) circle one

Date Obtained: ___/___/___ Test Done: QFT-GIT T-Spot Result: ___positive ___negative ___ indeterminate
Must provide a copy lab report

Chest Xray: (REQUIRED if TST or IGRA positive)

Date of chest Xray: ___/___/___ Result: ___normal ___abnormal **Must provide a copy of chest Xray report/results**

I have reviewed the information included in this questionnaire with the patient, their individual risk for infection, as well as signs and symptoms of an active TB infection and when the student should seek care.

____

Health care provider signature Date