**REVIEW OF SYSTEMS TO BE COMPLETED BY HEALTH CARE PROVIDER (OTHER THAN PARENT)**

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

<table>
<thead>
<tr>
<th>Ears, Eyes, Nose, Throat</th>
<th>Gastrointestinal</th>
<th>Neuro-psychologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes  ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>1. Eye Problems (blurred vision, infection, double vision, etc.)</td>
<td>19. Indigestion</td>
<td>34. Headaches</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>5. Frequent Sore Throats</td>
<td>23. Diarrhea</td>
<td>38. Sensory Loss</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td></td>
<td>25. Recurrent Abdominal Pain</td>
<td>40. Mood Disorder</td>
</tr>
<tr>
<td></td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td></td>
<td>26. Gastroesophageal Reflux</td>
<td>41. Eating Disorder</td>
</tr>
<tr>
<td></td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td></td>
<td>27. Celiac Disease</td>
<td>42. Sleeping Disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiac</th>
<th>Genito - Urinary</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
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<td>Yes ❑ No</td>
</tr>
<tr>
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<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>11. Other Heart Disease</td>
<td>32. Irregular Menses</td>
<td>Other</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>12. Wheezes-Asthma</td>
<td>49. Diabetes</td>
</tr>
<tr>
<td>13. Frequent Colds</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>14. Chronic Cough</td>
<td>50. History of Malaria</td>
</tr>
<tr>
<td>15. Treatment for Tuberculosis</td>
<td>Yes ❑ No</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>16. Exposure to Tuberculosis</td>
<td>51. Cancer</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>17. Smoker</td>
<td>Yes ❑ No</td>
</tr>
<tr>
<td>Yes ❑ No</td>
<td>18. Pneumonia</td>
<td>52. Other Chronic Disease or Disability</td>
</tr>
</tbody>
</table>

**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>
<tbody>
<tr>
<td>Visual Acuity:</td>
<td>with correction</td>
<td></td>
<td>without correction</td>
<td>left</td>
<td>right</td>
</tr>
<tr>
<td></td>
<td>left</td>
<td>right</td>
<td></td>
<td>left</td>
<td>right</td>
</tr>
</tbody>
</table>

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
- [ ] 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.  Signed ____________________________  M.D./D.O.

Address ____________________________  Telephone ____________________________  Date ____________________________
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

RECOMMENDED

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, Diphtheria, 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

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.
Bryn Mawr College Health Center Tuberculosis Screening Questionnaire

Student Name

Last Name First Name

DOB 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

(Update 6/2020)