Cooper Medical School of Rowan University

HEALTH HISTORY

(To be completed by the student. Please print or type)

Please send this document to CONCENTRA: dcinesi@concentra.com no later than July 1, 2023

(PLEASE DO NOT SEND TO CMSRU)

For any questions please call: Daniella/Terry at CONCENTRA (856) 338-0350

Name _____

(Last) (First) (MI)

Date of Birth: ____/____/____ ☐ Male ☐ Female

MM DD YYYY

Permanent Address: _____

Street & Apt. # City State Zip

Contact Telephone (Cell): _____ Email: _____

Preferred Primary Care Physician while attending CMSRU: ☐ CMSRU Student Health ☐ Other (enter physician info below)

_____

Physician Name Address Phone#

Emergency Contact: _____

Name Relationship Telephone

Describe your usual health: Excellent ___ Good ☐ Fair ☐ Poor

Do you exercise? Never Sometimes Often Type of exercise: _____

How much tobacco do you use? None <1/2PPD 1/2-1PPD ☐ >1PPD ☐ Other

How many alcoholic drinks do you have a week: ☐ None ☐ 1-3/wk ☐ 4-6/wk ☐ 7+/wk

Please list your medical history: _____

_____

Are you currently being treated for medical issues? ☐ Yes ☐ No If yes, specify diagnosis & date(s): _____

_____

Have you ever had surgery? ☐ Yes ☐ No If yes, specify procedure(s) and date(s): _____

_____

Any hospitalizations not specified above? ☐ Yes ☐ No If yes, specify reason(s) and date(s): _____

_____

Have you ever received treatment for anxiety, depression, eating disorders, alcohol or other substance abuse, or any other emotional/psychiatric problem? ☐ Yes ☐ No If yes, specify reason(s) and date(s): _____

_____

Please specify any allergies to medications, latex and other substances (include reaction). If none, write none. _____

_____

Please list any medications you take regularly. Include all prescription medications, contraceptives, non-prescription medications, vitamins, herbs, supplements, and homeopathic remedies: _____

_____

Has your activity been restricted in the past 5 years? ☐ Yes ☐ No If yes, specify reason(s) and date(s): _____

_____

Name _____

(Last) (First) (MI)

Health History (continued)

Is there a family (parents, siblings, grandparents) history of:

Hypertension	Yes	No	Who: _____	High Cholesterol	Yes	No	Who: _____
Heart Disease	Yes	No	Who: _____	Stroke	Yes	No	Who: _____
Diabetes	Yes	No	Who: _____				
Cancer	Yes	No	Who: _____ Type: _____				
Psychiatric	Yes	No	Who: _____ Type: _____				

For women: Have you had a regular gynecological exam and Pap smear? Yes No Date of last GYN visit/Pap test _____

Please list dates of your last exams: Vision Test _____ Dental Exam _____ Skin Cancer Screening _____ /

CERTIFY THAT THE ABOVE IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

_____

Patient Signature Date

Contents of this document will not be shared with anyone except those given HIPAA permissions and the CMSRU Office of Student Affairs, with notice given to the student, should there be an issue surrounding the health or safety of any individual(s) or a concern surrounding the student's ability to function in the CMSRU curriculum.

Any disclosure made to Student Health Services or on this form does not constitute notice to CMSRU of a disability or handicap and will not be considered a request for accommodation. All requests for reasonable accommodations must be made directly to CMSRU Accessibility Services.

PHYSICAL EXAM

(Must be completed by a non-relative physician, nurse practitioner, or physician's assistant)

Physical Exam Date: _____

Visual Acuity (with correction, if any): **OD** _____ **OS** _____ **Correction?** ☐ **Yes** ☐ **No**

Hearing Exam ☐ **Yes** ☐ **No** **Hearing Impairment** ☐ **Yes** ☐ **No**

Height (inches) _____ **Weight (pounds)** _____ **BMI** _____ **BP** _____ **Pulse** _____

	Normal	Abnormal	Not Done	If abnormal, please explain:
General appearance	☐	☐	☐	_____
Skin	☐	☐	☐	_____
Head	☐	☐	☐	_____
Eyes	☐	☐	☐	_____
Ears, Nose, Throat	☐	☐	☐	_____
Neck	☐	☐	☐	_____
Lymph Nodes	☐	☐	☐	_____
Breasts	☐	☐	☐	_____
Heart	☐	☐	☐	_____
Lungs	☐	☐	☐	_____
Abdomen	☐	☐	☐	_____
Pelvic Exam	☐	☐	☐	_____
GU Exam	☐	☐	☐	_____
Spine	☐	☐	☐	_____
Extremities	☐	☐	☐	_____
Neurological Exam	☐	☐	☐	_____

Does this student require ongoing medical care? ☐ **Yes** ☐ **No** **Specify:** _____

_____

HEATH CARE PROVIDER (must be completed): Date: _____

Print Name: _____ Signature: _____

Address: _____

Phone: _____ Fax: _____