NJIT
New Jersey's Science & Technology University

Mail or Fax All Forms To:
New Jersey Institute of Technology
Dean of Students and Campus Life
255 Campus Center, University Heights
Newark, NJ 07102
Website: **www.njit.edu/healthservices**
Office #: 973-596-3621 – ***Fax #:*** 973-388-2173
E-mail: healthservices@njit.edu

HEALTH HISTORY QUESTIONNAIRE PHYSICAL EXAMINATION

TO THE STUDENT: This information is required that NJIT Student Health Services can provide care based on our particular needs. This form becomes a part of your student health record. It as well as any other health care information obtained while you are at NJIT, are confidential and will not be released to anyone without your written permission. These records must be submitted prior to or the day of registration to Health Services. If your records are not submitted within this time, a ***HOLD*** will be placed on your future registration until you provide us with your records.

FULL TIME STUDENT REQUIREMENTS:
Tuberculosis Test within the past 6 months of your registration *(test result is needed)*
Measles (*Proof of two doses*) after your 1st birthday
Mumps (*Proof of two doses*) after your 1st birthday
Rubella (*Proof of two doses*) after your 1st birthday
Or a serology test for Mumps, Measles, and Rubella *(a lab report is needed)*
Physical Exam, by a physician (*within the past 6 month of your registration*)
Hepatitis B – Proof of 3 doses or lab evidence of immunity
Varicella (Chickenpox) *(Proof of two doses*) or lab evidence of immunity. Required
Tdap (within the past 10 years) required

PART-TIME STUDENT REQUIREMENTS
Same as full-time Student/No Physical Exam

MENINIGITIS VACCINE - Required for **ALL** Students

AGE EXEMPT REQUIREMENTS
Those born before 1957 are required to submit blood test (IgG) to document immunity to Measles, Mumps, or Rubella. It is suggested that you also be tested for immunity to Varicella (Chickenpox). You do need to submit documentation of all other requirements.

Check The Following: Undergraduate _____ Graduate _____Full-Time_____ Part-Time _____ EOP_____

Name: _____Date of Birth:_____/_____/_____
(Last) ***(First)*** ***(MI)***
NJIT I.D. #_____Phone #: ( ) _____ E-mail: _____

Address: _____
(Street) ***(City)*** ***(State/Country)*** ***(Zip Code)***

Campus or Local Address: _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Name: _____
(Last) ***(First)*** ***(MI)***
_____
(Street) ***(City)*** ***(State)*** ***(Zip Code)***

Phone Number: (_____)-_____E-Mail Address: _____

TO PARENTS AND GUARDIAN OF STUDENTS UNDER 18 YEARS OF AGE

I authorize the personnel of NJIT Health Services or authorized personnel of the University to proceed according to good medical practice in providing medical care of treatment to my child in an emergency or when unable to reach me for authorization.

Parent/Guardian's Signature: _____Relationship: _____Date: ____/____/____

PERSONAL HEALTH ASSESSMENT: For the following questions, please check yes if you are presently having a problem or have had a problem in the past. If there is no significant problem, check no. Briefly explain all yes answers. ***TO BE COMPLETED BY STUDENT.***

Drug Usage:	**Yes**	**No**
Please give information about drug usage alcohol, marijuana, smoking……	❑	❑
_____		
_____		

Cardiovascular:		
Heart murmur/palpitations…….....	❑	❑
Chest Pain…….	❑	❑
Rheumatic fever……..	❑	❑
High blood pressure…….	❑	❑
Irregular heartbeat…….	❑	❑
Blood clots (not menstrual clots)……..	❑	❑
Enlarge heart……	❑	❑
_____		

Respiratory:		
Asthma……	❑	❑
Chest infection……	❑	❑
Do you smoke cigarettes?.....	❑	❑
How many?_____How Long?_____		
Shortness of breath……	❑	❑
Wheezing……	❑	❑

Skin:		
Any problems with your skin?.....	❑	❑
Skin rashes…….	❑	❑
_____		
_____		

Endocrine:		
Thyroid disease…….	❑	❑
Diabetes……..	❑	❑

Urinary:		
Impaired function of any part of your Urinary tract or loss of a kidney	❑	❑
_____		
Kidney Stones:……	❑	❑

Mental Health:		
Any problems with your emotional health, requiring any form of therapy, including medications?.....	❑	❑
Have you ever experienced a serious dietary problem (anorexia, bulimia, obesity)	❑	❑

Medications:		
(birth control pills, vitamins, over-the counter-medications and prescriptions):	❑	❑
Amount:_____		
Usage Per day:_____		

Past Illness:	**Yes**	**No**
Malaria, Hepatitis, mononucleosis, Strep throat and other childhood diseases	❑	❑
Loss or absence of any body parts.	❑	❑
Severe/frequent colds or flu……	❑	❑
Chicken Pox (month/year)	❑	❑

Hospitalization:		
Have you ever been admitted to a hospital?.....	❑	❑
Have you ever had surgery?.....	❑	❑
_____		

EENT:		
Any problems with your eyes, ears, nose, or throat……	❑	❑
Hearing impairment……	❑	❑
Loss of eye or eyesight…….	❑	❑

Blood:		
Anemia……	❑	❑
Sickle-cell disease……..	❑	❑
Abnormal bleeding or bruising……..…..	❑	❑

Bone and Joint:		
Any serious disability deformity or disease of bone, joint, or muscle?.....	❑	❑
_____		

Neurology:		
Seizures or convulsions……	❑	❑
Fainting or blackouts……	❑	❑
Dizziness…….	❑	❑

Gastrointestinal:		
Problems with any part of your intestinal tract or stomach?.....	❑	❑
Jaundice……	❑	❑
Hernia……	❑	❑
_____	❑	❑

Reproductive System (men):		
Prostate trouble…….	❑	❑
Swelling of the scrotum or testicle…….	❑	❑
Undescended or absent testicle……..	❑	❑
Do you perform testicular self-examination?_____	❑	❑

Reproductive System (women):		
Never had a menstrual period?.....	❑	❑
Any form of menstrual disorder?.....	❑	❑
Do you perform breast self-exam……	❑	❑
Last menstrual period_____		

Allergy:	**Yes**	**No**
Any significant allergy to food, medications, insects, pollen?.....	❑	❑
Food? …….	❑	❑
Other? ……	❑	❑

_____

Family History:

Age and Health, if living, or Cause of Death:
Father:_____
Mother:_____
Brother:_____
Sisters:_____

Check the following diseases that have appeared among parents, grandparents, and siblings:

- ❑ Tuberculosis _____
- ❑ Diabetes _____
- ❑ Cancer (type) _____
- ❑ Seizure disorder _____
- ❑ Stroke _____
- ❑ Heart disease _____
- ❑ Kidney disease _____
- ❑ Emotional illness _____
- ❑ High blood pressure _____
- ❑ Problems with alcohol/drugs _____
- ❑ Asthma _____
- ❑ Other _____

***Comments*:** _____

_____

_____

To The Student:

I certify that the statements in Section 1& II are true to the best of my knowledge, and I consent to treatment in the Student Health Services with the understanding that all services rendered are confidential.

Student Signature: _____ Date:_____/_____/_____

NJIT PHYSICAL EXAMINATION

(Completed by physician)

TO THE PHYSICIAN: Please review the student's personal history and complete the form below. Comment on all abnormal findings. This student has been accepted at New Jersey Institute of Technology and this information will note his/her medical status. It will be used only as a background for providing health care. This information is strictly for the use of the Health Services and will not be released without the written permission of the students.

Name:_____Date of Birth:____/____/____
(Last) ***(First)*** ***(MI)***

Height:_____Weight_____BP_____Pulse_____

Vision: Uncorrected Right _____Left_____Corrected Right _____Left _____

ASSESSMENT:

	Normal	Abnormal
1. Eyes ……..	_____	_____
2. Ears ……..	_____	_____
3. Nose, throat ……..	_____	_____
4. Neck/thyroid …….	_____	_____
5. Chest, lungs …….	_____	_____
6. Cardiovascular …….	_____	_____
7. Abdomen, liver, spleen ……..	_____	_____
8. Genitalia, hernia ……	_____	_____
9. Nervous system, balance ……..	_____	_____
10. Skin …….	_____	_____
11. Musculosketetal ……..	_____	_____
Upper extremity: AC joints, shoulder stability, symmetry, range of motion		
Spine: Neck-ROM, forward bend, curve …….	_____	_____
Lower extremity: range of motion, symmetry ……	_____	_____
Ligaments, gait, knees, ankles ……	_____	_____
12. Psychological …….	_____	_____
13. Other …….	_____	_____

ABNORMAL FINDINGS:

COMMENTS: Recommendations, continuing treatment, restrictions:

_____
_____
_____
_____

I have reviewed the clinical history as given by the student and after performing a physical exam, I certify that this student is able to participate in physical education and intramural activities without restrictions.

May _____ May not _____ Participation In _____
(Name of Sport)

Examiner's Signature _____Date _____/_____/_____

Print Name _____Phone #_____

Address _____
(Street) ***(City)*** ***(State)*** ***(Zip Code)***