HEALTH HISTORY FORM

TO BE COMPLETED BY STUDENT

Return to: **TOURO COLLEGE OF OSTEOPATHIC MEDICINE – NEW**
230 West 125th Street, New York, NY 10027
Telephone: 646-981-4500 Fax: 212-678-1785

Name _____ **Sex** _____ **Date** _____

Address _____

Date of Birth _____ **Social Security #**_____

Telephone _____ **Cell** _____

Email _____

Emergency Contact Name/Telephone _____

Past Health History (circle)
Hypertension Cancer Hepatitis A-B-C Ulcers Asthma Bronchitis Arthritis Thyroid Anemia TB Diabetes 1-2 Kidney Disease Eczema Rheumatic Fever Heart Murmurs Severe Eyesight Disturbances Severe Allergies Hearing Problems Blood Clots Stroke Ulcers Sexually Transmitted Diseases (STD's) Depression Anxiety Suicidal Attempts Heart Disease Elevated Lipids Back Deformities Locomotion Challenges Deafness Blindness Herpes Speech Challenges Abnormal Pap Prostate Abnormalities Testicular Disease Mononucleosis

Surgical history _____

Hospitalizations (dates/cause/treatments) _____
_____

Social history Smoker ____ Years Alcohol ____ Drugs ___ Exposure to environmental toxins _____

Current medications _____

Allergies Drug Allergy (names) _____
Environmental/Latex _____

Family History

Mother	L	D	Health Status
Father	L	D	Health Status
Children	L	D	Health Status
Siblings	L	D	Health Status

Symptom Review (circle) Fever Weight Gain/Loss Chills Sweats Loss of Appetite Nervous Tired Hair Loss Skin Rashes Sores Headache Blurred Vision Double Vision Ear Ringing Vertigo Trouble Hearing Frequent Nose Bleeds Sinus Troubles Bleeding Gums Frequent Strep Throat Neck Pains Chest Pains Shortness of Breath/Trouble Breathing Rapid Heart Beats Varicose Veins Scoliosis Kyphosis Wheezing Night Sweats Breast Lumps Breast Discharge Heartburn Rectal Bleeding Trouble Voiding Burning on Urination Testicular Masses Old Spinal Injuries Depression Anxiety Seizures

PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY HEALTH CARE PROVIDER

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Telephone: 646-981-4500 Fax: 212-678-1785

Name _____

Date of Birth _____ **Sex** _____

Height _____ **Weight** _____ **B/P** _____ **T** _____ **P** _____ **R** _____

Vision **Distance Uncorrected** **R 20/____** **L 20/ ____** **Corrected** **R/20/ ____** **L20/____**

Color Vision **Normal** _____ **Deficient** _____

	Normal	Abnormal	Description of abnormalities (if any)
Skin	**n**	**a**	
Eyes	**n**	**a**	
Ears	**n**	**a**	
Nose/Sinus	**n**	**a**	
Throat/Neck	**n**	**a**	
Chest/Thorax	**n**	**a**	
Heart	**n**	**a**	
Lungs	**n**	**a**	
Abdomen	**n**	**a**	
Extremities	**n**	**a**	
Osteopathic Structural Exam	**n**	**a**	
Neuro	**n**	**a**	
Psych/Mental	**n**	**a**	
Genito-Urinary	**n**	**a**	

I have examined this potential Touro College of Osteopathic Medicine - NY student and found that he/she:
A. May participate fully in all activities involved without restriction.
B. May participate with the following restrictions or accommodations.
C. May not participate, due to issues of safety/other.

Health Care Provider:

Name (Print):_____
Address: _____
City, State: _____
Telephone: _____
Facsimile: _____
E-Mail: _____
Signature: _____
Date: _____