Touro College of Osteopathic Medicine **HEALTH PROVIDER SIGNATURE REQUIRED**

HEALTH HISTORY FORM

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

Address: _____

Date of Birth (MM/DD/YYYY) _____ **Social Security #**: _____

Telephone: _____ **Cell**: _____

TOURO Email: _____

Emergency Contact: **Name**: _____ **Phone**: _____

Past Health History (circle all applicable)

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

Surgical History: _____

Hospitalizations (dates/cause/treatments) _____

Social History:

Number of Years: Smoker ___ Alcohol ___ Drugs ___ Exposure to environmental toxins ____

Current Medications: _____

Allergies:

Drug Allergy (names): Environmental/Latex:

_____ _____

_____ _____

Family History:

Mother: Living / Deceased Health Status: _____

Father: Living / Deceased Health Status: _____

Sibling(s): Living / Deceased Health Status: _____

Children: Living / Deceased Health Status: _____

Symptom Review (circle all applicable)

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

Student Signature: _____ **Physician Signature:** _____

Touro College of Osteopathic Medicine

PHYSICAL EXAMINATION FORM

COMPLETED BY HEALTH CARE PROVIDER

Performed on: _____

Name (last name, first name) _____

Date of Birth (MM/DD/YYYY) _____ 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)	Not performed
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: (Please select one)

___ 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: _____
Signature: _____
Date: _____

Touro College of Osteopathic Medicine

TUBERCULOSIS SCREENING

COMPLETED BY HEALTH CARE PROVIDER

Name: _____ **Sex**: ____ **DOB** (MM/DD/YYYY) _____

TUBERCULOSIS SCREENING | OPTIONS: Two-step PPD | QuantiFERION Gold | Chest X-Ray
Must be completed between Late February- April

(A) Two-step PPD: □ **Attached Copy**

(#1) Date Applied: _____ Date Read: _____ Induration: _____ mm

(#2) Date Applied: _____ Date Read: _____ Induration: _____ mm

(B) Quantiferion Gold Test: Date: _____ Result: _____ □ *Attached lab work* ***(required)***

STUDENTS WHO ARE POSITIVE PPD REACTORS (LATENT Tb) OR CONVERTERS WITH PREVIOUSLY OR NEWLY POSITIVE SKIN TESTS, PLEASE COMPLETE SECTION B or C

(C) First positive skin test date: _____ Result (mm) if known: _____

BCG given in past: _____ Yes _____ No (*If yes, provide approximate date of last BCG*_____)

Date of Last CXR: _____ Result: _____ (□ **Attach Copy**)

Dates of any treatment (INH prophylaxis for 6-9 months):_____

If no treatment and under 35 years old, why was treatment not given? _____

STUDENT REACTORS (LATENT Tb) OR CONVERTERS COMPLETE THE FOLLOWING SYMPTOM CHECKLIST:

Have you recently:
Had an unexplained cough lasting more than 4 weeks? Yes / No
Had sputum production? Yes / No
Had an unexplained fever? Yes / No **Student Initials**: _____
Had unexplained weight loss? Yes / No
Had fever, night sweats or chills? Yes / No **Date:** _____

Health Care Provider: I attest that all dates and Tuberculosis screening results are correct and accurate.

Name (Print):_____
Address: _____
City, State: _____
Telephone: _____
Signature: _____
Date: _____