UNIVERSITY HEALTH SERVICES

HIGHLY RECOMMENDED FOR INCOMING STUDENTS WITH EXISTING MEDICAL CONDITIONS, ON MEDICATIONS, OR HISTORY OF ALLERGIC REACTIONS.

NAME:_____ **Fordham ID#:**_____ **DOB:**_____

CELL #_____ **CAMPUS:** _____ **DATE OF EXAM:** _____(to be completed only by MD, NP or PA forms completed by parents will not be accepted)

PERSONAL HISTORY Do you have now or have you ever had (check all that apply)

1. Acne
2. Anemia
3. Anorexia/Bulimia
4. Appendectomy
5. Arthritis
6. Asthma
7. Blind/visual impairment
8. Cancer/malignancy
9. Deaf/Hearing impaired
10. Depression
11. Diabetes
12. Emotional/Mental illness
13. Hepatitis
14. High Blood Pressure
15. High Cholesterol
16. HIV infection/disease
17. Impaired mobility/paralysis
18. Kidney disease
19. Malaria
20. Migraines/headaches
21. Mononucleosis
22. Neuromuscular Disease
23. Phlebitis/Deep vein clot
24. Pneumothorax
25. Positive TB Test
26. Seizure disorder
27. Sickle Cell Disease
28. Thyroid Disease
29. TB/tuberculosis
30. Ulcer/Stomach problem
31. UTI's (frequent)
32. (Other_____)

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates):_____

_____

FAMILY HISTORY List anyone in your immediate family with significant health problems (i.e. Diabetes, cancer)

_____

Height: _____ **Weight:** _____**BP:** _____**Pulse:** _____**Vision: R 20/ L 20/**

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if indicated)		
Genitourinary		
Pelvic (if indicated)		
Musculoskeletal		
Neurological		
Psychological		
Other:		

UNIVERSITY HEALTH SERVICES

Student's Name_____ **Fordham ID #: A**_____

DOB: _____

CURRENT & CHRONIC PROBLEMS

1._____ 2._____3. _____

IF THE STUDENT IS UNDER CARE FOR A CHRONIC OR SERIOUS ILLNESS, PLEASE ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

CURRENT MEDICATIONS: _____

ALLERGIES (medications, environmental, foods): _____

Type of reaction: _____

If history of Anaphylaxis, please call the UHS @ 718-817-4160 to speak with a staff member.

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: Unlimited Limited (specify):_____

Health Care Provider (please print) _____

Address: _____

Phone :(____) _____Fax :(_____) _____

Provider's Signature: _____

Once your health care provider has completed this form, make a copy for your records and scan into your Fordham Student Health Portal (preferred method). The Student Health Portal is located on your my.fordham.edu site under My Apps. Log in using your my.fordham.edu credentials. Go to Document Upload, select Physical forms and upload.

If you cannot upload to the Student Health Portal, you may mail, fax or email this form.

Fordham University Health Services
Attn: Immunizations
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Bronx, NY 10458
718-817-3218 fax
Health@fordham.edu