DEPARTMENT OF MIDWIFERY

HEALTH QUESTIONNAIRE FOR VISITING STUDENTS

Name:____ DOB: __________

School/Department:

TO THE HEALTH PROVIDER

1. Does this student have any acute or chronic health problems? If yes, please explain:

a. Is the student currently taking any prescription medications?

b. Does the student have any special dietary needs? Please specify:

c. Does the student have any allergies to food or medicine? Please specify:

2. Date of last physical exam (must be no more than one year prior to visit):

Result of exam:

3. PROOF OF IMMUNITY TO MEASLES, MUMPS AND RUBELLA IS REQUIRED. ONE DOSE OF LIVE MUMPS AND RUBELLA VACCINES AFTER FIRST BIRTHDAY, TWO DOSES OF LIVE MEASLES VACCINE AFTER FIRST BIRTHDAY, OR IMMUNE TITRES WILL SATISFY THE REQUIREMENT.

Measles vaccine: __________ __________ or titre__________

No.1 date No.2 date

Mumps vaccine: __________ or titre__________

Date

Rubella vaccine: __________ or titre__________

4. FOR ANY STUDENT WORKING WITH BLOOD OR BODY TISSUES OR

HAVING DIRECT PATIENT CONTACT THE FOLLOWING IS REQUIRED:

Not required for students from the State University of New York Downstate Medical Center, United States.

Hepatitis B Surface Antigen and Antibodies: _______________________

Date of 5 Year booster: ______________________

Hepatitis C Antibodies: _____________________

HIV Antibodies: ___________________________

5. HISTORY OF CHICKEN POX/VARICELLA? Yes: __________ No:---------

If no, Varicella vaccine: __________ __________

No.1 date No. 2 date

6. TUBERCULIN TEST (If known negative, Mantoux test must be administered within six months prior to elective).

Date of Last Test: __________ Result: __________mm induration

Chest X-ray (required if Mantoux Test positive):

Date: __________ Result: __________

I certify that the above statements are true.

Signature of Health Care Provider: _______________________________

Address: _______________________________

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Telephone Number: _______________________________