SUNY HEALTH SCIENCE CENTER AT BROOKLYN
HEALTH ASSESSMENT

Indicate appropriate program and graduating year. Sign and date at bottom of page. Return this form in person to the SHS or by fax to 718-270-2477. Our mail address in Box 33. Registration will not be complete until this form is received by the SHS. All health information is confidential.

*MEDICINE: Class of*_____ *CHRP: Class of*_____ *NURSING: Class of*_____

NAME: _____ SID: _____

PRESENT ADDRESS _____ HSC BOX#: _____

_____

PRESENT TEL. # _____ PAGER/CELL PHONE _____

1. Have you had any illnesses in the past year? _____yes _____no
   If yes, please explain:_____

2. If you have had a negative PPD in the past, since your last health assessment at the Student Health Service, has your tuberculin test become positive? _____yes_____no_____n/a

3. OSHA requires that health care givers wear a special high filtration mask when in contact with a patient with active tuberculosis. You are required by OSHA to answer the following questions and come to the SHS for a mask fitting. (If you do not have patient contact, indicate with n/a)

   a. Have you ever worn a mask as described above? _____yes _____no
   b. Do you have problems using such a mask? _____yes _____no

      If yes, please explain:_____

   c. Do you have any chronic disease, especially pulmonary or cardiac? _____yes_____no

      If yes, please explain:_____

   d. Do you take any medications?_____If yes, please list:_____

      _____

4. Are you a habitual user of stimulants, depressants, alchohol or other addictive substances?
   _____yes_____no

I certify that the above statements are true and correct to the best of my knowledge.

*Student's signature*_____ *Date* _____

Student Health Services

450 Clarkson Ave. MSC 33, Brooklyn, NY 11203
Phone: 718-270-2018/1995 Fax: 718-270-2901