SUNY DOWNSTATE MEDICAL CENTER
STUDENT HEALTH SERVICE
450 CLARKSON AVENUE, MSC33
BROOKLYN, NEW YORK 11203-2098
(718) 270-2018/1995 • FAX (718) 270- 2901/2477

Program: (Check all that apply.)

☐ MD Nursing: ☐ Accelerated BS
☐ Graduate ☐ RN-BSN CHRP:
☐ MPH ☐ Graduate _____
(Indicate CHRP Program)

DATE: _____

HISTORY AND PHYSICAL EXAMINATION FORM

This form should be filled out by the student and by the examining physician. You must answer all questions even if the answer is NO, NONE, or N/A. Mail to the above address.

1. Name_____ Gender: Male/Female S.S.#_____

Home Address_____ Telephone_____

City/State/Zip_____ Country of birth_____

Email _____ Birth date_____

Undergraduate College_____ Date of Grad._____

Person to notify in case of emergency_____ Telephone_____

Health Insurance Company_____ Policy #_____

2. **Past Medical History**

Describe any past history of medical /surgical illness.

_____

Please indicate any acute or chronic medical conditions. _____

_____

Do you have or have you had any history of mental health disorder? ___ Please explain. _____

_____

Please describe any allergies to medications, foods, or other substances. _____

_____

Do you take any medications on a regular basis? _____ Please specify._____

_____

Do you now or have you in the past habitually used drugs or alcohol? _____

_____

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

_____ _____
Applicant's Signature Date

(OVER)

Physician's Form

To the examining physician: Please review the history form on the reverse side and add any pertinent information. **Physical examination, lab tests, and tuberculin testing with Mantoux technique , or blood-based tuberculosis test are required.**

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3. **Physical Examination**

_____ has had a complete history and physical
Student's Name

examination on _____, B.P._____ weight_____ height_____

Findings are as follows:

_____ I find the applicant to have a history of the following medical or surgical conditions:_____

_____

_____

_____

_____ I find the applicant to be in good physical and mental health with no condition necessitating the continuation of care.

_____ I find the applicant has the following health condition for which **continuation of care** is required or which may adversely affect his/her educational experience: (If continued care is required, a complete description of the condition and care required should be included.)

_____

_____

_____

Except as noted, the above student is in good physical and mental health and has no problem that might interfere with his or her ability to pursue professional studies.

_____ _____
Name of Physician Date

_____ _____
Signature of Physician Address

_____ _____
State and License number Telephone

Reviewed by_____SHS