



# Pre-entrance Health History and Physical Exam

*Please read these instructions before filling out the Health History and Physical Exam Forms.*

## **Health History**

Complete this to the best of your ability, date and sign. The next of kin and emergency contact information is very important for our records and will be used only in the case of a life-threatening emergency.

## **Physical Examination**

This form must be completed and signed by your provider with the date of the examination clearly noted. The exam must have been completed after **September 2008** for fall entrants and **January 2009** for spring entrants. If you will be participating in either, varsity or club sports, the exam must have been completed after **March 2009** for fall entrants or **August 2009** for spring entrants.

**DUE DATE: JULY 1, 2009**



# Medical History Report

Mount Holyoke College, Pattie J. Groves Health Center  
South Hadley, MA 01075-1458

**To the Student:** Information you provide will be used as an aid to providing necessary health care while you are a student. This information is strictly for the use of Health Services, Counseling Services staff, and the athletic trainer for participants in intercollegiate sports. Information will not be released to others without your knowledge and consent.

**Social Security No.** \_\_\_\_\_

*Please complete this side of the form before going to your physician for examination.*

LAST NAME (PRINT)	FIRST NAME	MIDDLE	PREFERRED
HOME ADDRESS (Number and Street)	CITY OR TOWN	STATE	ZIP CODE
NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN			DATE OF BIRTH
EMERGENCY CONTACT PERSON (If different from above)			DAYTIME PHONE
			EVENING PHONE
			CELL PHONE

**FAMILY HISTORY**

	Living or Deceased	Present Age or Age at Death	State of Health or Cause of Death	Occupation
FATHER				
MOTHER				
SIBLINGS M/F				
M/F				
M/F				
SPOUSE				
CHILDREN M/F				
M/F				

**Have any of your blood relatives ever had any of the following?**

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Cancer			
Allergy/Asthma			
Stroke/High Blood Pressure			
Nervous or Mental Disorder			
Alcohol/Drug Problem			
Neurologic Disease			
Sudden death under age 50			

**PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on a separate sheet.**

HAVE YOU HAD?	Yes	No		Yes	No		Yes	No
Chicken Pox			Alcohol/Drug Problem			Pain/Pressure in Chest/Palpitations		
Malaria			Headache Migraine			High or Low Blood Pressure		
Mononucleosis			Headache Other			Heart Murmur/Condition		
Meningitis			Fatigue			Epilepsy, Convulsions		
Sinusitis			Eye, Ear, Nose, Throat Disorder			Diabetes		
Whooping Cough			Speech or Hearing Problem			Thyroid/Endocrine		
Tuberculosis			Skin Disorder			Kidney Disease		
Pneumonia			Allergic Rhinitis			Disease or Injury of Joints		
Surgery			Asthma (including exercise induced)			Back Problems		
Appendectomy			Allergy (Describe Reaction)			Tumor, Cancer, Cyst		
Tonsillectomy			Penicillin			Jaundice (Hepatitis)		
Surgical removal or congenital absence of any organ			Sulfa			Stomach or Intestinal Disorder		
Other			Food			Head Injury/Concussion		
Insomnia			Stinging Insects					
Frequent Anxiety			Latex					
Frequent Depression			Other					

	Yes	No
Sexually Transmitted Infection		
Anorexia/Bulimia		
Recent Weight Change > 10lbs		
Dizziness/Fainting/Chest Pain (including exercise or heat induced)		
Weakness, Paralysis		

Menstrual History  
Age of onset  
Interval  
Duration  
Discomfort  
Medication  
History of irregularity

	Yes	No
A. Has your physical activity been restricted during the past five years and/or do you have a current orthopedic condition?		
B. Have you received any psychiatric treatment or psychological counseling for emotional problems?		
C. Have you ever been hospitalized? (Give details)		
D. Do you have any other illness or injury not already noted?		
E. Are you currently taking any medication on a regular basis? Name/Dosage/Reason		

**REMARKS OR ADDITIONAL INFORMATION**

Student's Signature \_\_\_\_\_

Date \_\_\_\_\_

# Physical Examination

Mount Holyoke College, Pattie J. Groves Health Center South Hadley, MA 01075-1458

**To the examining clinician:** Please review the student's history and complete the physical exam. Please comment on all positive answers. This student has been accepted. The information supplied will not affect her status; it will be used only as a background for providing health care. This information is strictly for the use of Health Services staff or the athletic trainer when indicated and will not be released without student consent. **It is expected that a full sports-oriented physical will be performed. THIS FORM CANNOT BE COMPLETED BY PARENT/GUARDIAN.** Physical exams must be completed in the 12 months prior to entering Mount Holyoke College. For participation in competitive athletics, the physical exam must be completed within six months of entering Mount Holyoke College.

STUDENT'S LAST NAME (PRINT)	FIRST NAME	DATE OF BIRTH
Height _____	Weight _____	Vision Right _____ / _____ with/without corrective lens
B. P. (R) arm _____ (L) arm _____	Pulse _____	Left _____ / _____ with/without corrective lens
HGB or HCT _____	Date _____	Both _____ / _____ with/without corrective lens
		Pupils Equal <input type="radio"/> Unequal <input type="radio"/>

	Norm	Abn	COMMENTS
1. Eyes, ears, nose, throat			
2. Neck (soft tissue)			
3. Cardiovascular	Auscultation:		Supine
			Standing
	Pulses:		Radial
			Femoral
Pulses equal and simultaneous: Yes <input type="radio"/> No <input type="radio"/>			
4. Chest & lungs			
5. Breast			
6. Abdomen			
7. Skin & lymph			
8. Neck (orthopedic)			
9. Spine			
10. Shoulders			
11. Arms & hands			
12. Hips			
13. Knees			
14. Ankles and feet			
15. Neurological			
16. Pelvic (optional)			

Comment on any consultation, treatment, hospitalization, or diagnostic studies in the past two years (other than routine).

Do you have any recommendations regarding the care of this student? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Is the patient now under treatment for any medical or emotional condition? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Recommendations for physical activity (PE, intramurals): Unlimited \_\_\_\_\_ Limited \_\_\_\_\_ Explain: \_\_\_\_\_

**HEALTH CARE PROVIDER SIGNATURE REQUIRED** **Date of Examination** \_\_\_\_\_

Name: (Print) \_\_\_\_\_ Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_