

New Student Medical History and Physical Examination

Lawrence University Health Services • 711 E. Boldt Way • Appleton, WI 54911-0599 • Phone: 920-832-6574 • Fax: 920-832-7488

Wisconsin law states that you must have this form completed with an accurate immunization history **BEFORE** you will be allowed to register for classes during Welcome Week web registration.

First name: _____ MI: _____ Last name: _____ LU ID: _____
 Date of birth: ___/___/___ Age: _____ Sex: _____ Class Year: Fr So Jr Sr
 Home address: _____ City: _____ State: _____ Zip: _____
 Home phone: _____ Cell phone: _____ Date form completed: ___/___/___

INSTRUCTIONS:

1. Please fill out Part I (sections A-D) before physical examination and then take it with you to your physical examination.
2. Part II must be filled out by a healthcare provider.
3. Please complete Tuberculosis (TB) Screening Questionnaire. **Any "Yes" responses on the questionnaire require physician completion of the Tuberculosis (TB) Risk Assessment form.**
4. Make sure all forms are signed by you (or parent/guardian if under 18) or by your healthcare provider where indicated.
5. Please provide a copy of your insurance card **FRONT AND BACK**. Check here if uninsured _____
6. This form must be filed with University Health Services by **August 1**.
7. If you are participating in Lawrence University Varsity Athletics, a copy of this form must also be sent to the Head Athletic Trainer in the Athletics Department by August 1. Please list your sport(s): _____

Part I - Medical History

A. Immunizations-date of **MOST RECENT** immunization or active disease.

- Measles, Mumps, Rubella- **TWO DOSES REQUIRED** to be able to reside in university housing.
- Tetanus immunization within the past five years is recommended.
- Chicken pox (if you have not had the disease) and meningitis vaccinations are strongly recommended.

Required - dates must be included (you cannot register without the state required immunizations)

1. Tetanus, Diphtheria, Pertussis (Tdap): ___/___/___
2. Polio: ___/___/___
3. Measles: #1 ___/___/___ #2 ___/___/___
4. Mumps: #1 ___/___/___ #2 ___/___/___
5. Rubella: #1 ___/___/___ #2 ___/___/___
6. Hepatitis B: #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
 (This series may be started at home and completed at Lawrence University)

Optional

1. BCG (if not born in the USA): ___/___/___
2. Chicken Pox immunization: ___/___/___ or natural disease ___/___/___
3. Meningitis immunization: ___/___/___
4. Human Papillomavirus (HPV): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
5. Other (Typhoid, Hepatitis A, etc) _____

B. Medications - Please list current medications and supplements, prescription and over the counter.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

C. Allergies - Please indicate which allergies you have and explain reactions below.

	Yes	No		Yes	No
Aspirin/Anti-Inflammatories			Penicillin		
Codeine			Sulfa		
Hay Fever/Seasonal			Any Foods		
Insect Stings/Bites			Other:		
Latex					

Please explain reactions: _____

New Student Medical History and Physical Examination

Lawrence University Health Services • 711 E. Boldt Way • Appleton, WI 54911-0599 • Phone: 920-832-6574 • Fax: 920-832-7488

D. Medical History - Explain **“Yes”** answers below. Circle any questions you don’t know the answer to.

FAMILY HISTORY – Has anyone in your immediate family had any of the following?					
	Yes	No		Yes	No
Abnormal Heart Rate/Palpitation			Heart Murmur		
Blood Disorder			High Blood Pressure/Hypertension		
Diabetes			Marfan Syndrome		
Epilepsy			Psychiatric Illness		
Heart Disease/Heart Attack			Sudden Death (before 50)		
PERSONAL HISTORY – Have you ever or do you currently have any of the following conditions?					
	Yes	No		Yes	No
ADD/ADHD			Hearing Impairment/Loss or Ear Problems		
Anemia			Physical Handicap		
Asthma/Breathing Problems			Skin Conditions (ie: rash, acne, warts, infections)		
Autism/Aspergers Syndrome			Sleep Disorder		
Diabetes (Type I or II)			Tested positive for Sickle-Cell Trait or Disease		
Eating Disorder			Tumor/Growth/Cancer/Cyst		
Emotional Disturbance (Anxiety/Depression)			Visual Impairment/Loss or Eye Problems		
Emotional Trauma			Other:		

GENERAL QUESTIONS	Yes	No	BONE AND JOINT QUESTIONS	Yes	No
1. Have you had a medical illness or injury since your last check-up or physical?			27. Do you use any specific equipment or devices that aren't usually used for your sport or position (ie: pads, braces, neck roll, orthotics, mouth guard)?		
2. Do you have an ongoing chronic illness or condition?			28. Do you have a pin, screw, or plate in your body?		
3. Have you ever been hospitalized overnight?			29. Have you ever had a stress fracture?		
4. Have you ever had surgery?			30. Have you ever had an injury that required that required x-rays, MRI, CT scan, brace, cast, or crutches.		
5. Has a doctor ever denied or restricted your participation in sports for any reason?			If yes to the following questions, check appropriate body part and explain:		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you ever broken or fractured any bones and/or dislocated or subluxed any joints?		
6. Have you ever passed out, felt lightheaded, or been dizzy during or after exercise?			32. Have you ever had a sprain, strain, or swelling after injury?		
7. Have you ever had chest pain during or after exercise?			33. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		
8. Does your heart race or skip beats during exercise?			___ Head ___ Neck ___ Spine ___ Chest ___ Back ___ Shoulder ___ Upper Arm ___ Elbow ___ Forearm ___ Wrist ___ Hand ___ Back ___ Hip ___ Thigh ___ Knee ___ Shin/Calf ___ Ankle ___ Foot		
9. Have you had high blood pressure or high cholesterol?			34. Do you have any concerns you wish to discuss with a doctor?		
10. Have you been told you have a heart murmur?			EXPLAIN ANY “YES” ANSWERS HERE		
11. Do you get tired more quickly than your friends do during exercise?			_____		
12. Have you had severe viral infection (ie: myocarditis or mononucleosis) recently.			_____		
MEDICAL QUESTIONS	Yes	No	_____		
13. Were you born without or are you missing a kidney, eye, spleen, testicle (males), or any other organ?			_____		
14. Do you cough, wheeze, or have trouble breathing during or after activity?			_____		
15. Have you ever had a head injury or concussion? If so, how many and when?			_____		
16. Have you ever been knocked out, become unconscious, or lost your memory?			_____		
17. Have you ever had a stinger or burner?			_____		
18. Have you ever had a seizure?			_____		
19. Have you ever had numbness or tingling in your arms, hands, legs or feet?			_____		
20. Do you have frequent or severe headaches?			_____		
21. Have you ever become ill from exercising in the heat?			_____		
22. Do you wear glasses, contacts, or protective eyewear?			_____		
23. Do you wear any dental appliances?			_____		
24. Do you worry about your weight?			_____		
25. Are you on a special diet or avoid certain foods?			_____		
26. Have you had a significant weight change recently?			_____		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student _____ **Date** ____/____/____

Signature of Parent/Guardian (if student is under 18) _____

New Student Medical History and Physical Examination

Lawrence University Health Services • 711 E. Boldt Way • Appleton, WI 54911-0599 • Phone: 920-832-6574 • Fax: 920-832-7488



This next section is to be filled out by a healthcare provider only.

Part II - Physical Examination- This form is NOT acceptable without a healthcare provider's signature.

Name: _____ Date of birth: ___/___/___ Date of exam: ___/___/___
Height: ___ inches Weight: ___ pounds Pulse: ___ bpm BP: ___/___ (___/___, ___/___)
Vision: R 20/___ L 20/___ Corrected: Y N Pupils: Equal___ Unequal___ Hearing: R ___ L ___

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
Neurological			
Genitalia/Pelvic (Optional)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

CLEARANCE

___ Cleared

___ Cleared after completing evaluation/rehabilitation for: _____

___ Not cleared for: _____ Reason: _____

Recommendations: _____

This is to certify that, in my opinion, _____ is in good health except as noted above, and is able to participate fully in academic work, physical education programs, and intercollegiate athletics.

Healthcare provider's signature: _____ Date: ___/___/___

Healthcare provider's name (print/type): _____

Address: _____ Phone: _____