Icahn School of Medicine at Mount Sinai

Student Health Center

Mount Sinai
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574

Tel: (212) 241-6023
Fax: (212) 241-8008
studenthealth@mssm.edu

STUDENT HEALTH SERVICE
ANNUAL HEALTH ASSESSMENT

STUDENT INFORMATION

Student Name (First, Middle Initial , Last):			**Class of:**
Telephone Number: ☐ HOME ☐ CELL	**Email:**	**Age:**	**Sex:** ☐ MALE ☐ FEMALE

HEALTH ASSESSMENT

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you experienced any of the following in the past year?

   Blood or body fluid exposure ☐ No ☐ Yes

   If yes, did you report this? Please comment on any follow-up or post-exposure prophylaxis: ____________________

   ____

Rash	☐ No	☐ Yes	Jaundice	☐ No	☐ Yes
Back Pain	☐ No	☐ Yes	Night Sweats	☐ No	☐ Yes
Fever	☐ No	☐ Yes	Cough	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes	Wheezing	☐ No	☐ Yes
Shortness of Breath	☐ No	☐ Yes	Chest Pain	☐ No	☐ Yes
Fainting	☐ No	☐ Yes			
Change in bowel habits	☐ No	☐ Yes			

2. In the past year, have you been told that you have high blood pressure, diabetes, heart disease, cancer, thyroid disease, kidney disease or any major illness? ☐ No ☐ Yes

   If yes, please explain: ____

3. In the past year, have you had surgery? ☐ No ☐ Yes

   If yes, please explain: ____

4. Please list any medications that you are currently taking.

   Medication: ____

   Medication: ____

   Medication: ____

5. Medicine Allergies: ____

6. Do you directly handle or transport lab animals at work? ☐ No ☐ Yes

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Health Assessment, Continued

7. Women only: When was your last Pap smear? ______________________________

8. Do you smoke? ☐ No ☐ Yes How much per day? ______________________________

9. Have you been concerned about your use of alcohol or recreational drugs? ☐ No ☐ Yes

   If yes, would you like to talk confidentially to someone about it? ☐ No ☐ Yes

10. What do you feel are your principal health problems, if any: ______________________________

____

11. If you are PPD +, please answer the questions listed below:

   A. Do you have a persistent cough? ☐ No ☐ Yes
   B. Do you have fevers? ☐ No ☐ Yes
   C. Do you have weight loss? ☐ No ☐ Yes
   D. Do you have night sweats? ☐ No ☐ Yes

Signature

Please Sign Here:

Student Signature: ______________________________ Date: ______________

Print Name: ______________________________

For SHS Use Only

Reviewed by: ______________________________ Date: ______________

Recall ☐ Yes ______________________________