Icahn School of Medicine at Mount Sinai

Student Health Center
One Gustave L. Levy Place
New York, NY 10029
Tele: (212) 241-6023

Student Health Center
ANNUAL HEALTH ASSESSMENT

This Annual Health Assessment is done for the purpose of determining limitations in your ability to engage safely and productively in your educational activities. It should not be considered a substitute for regular medical care by a physician. The relationship between you and Student Health Center is confidential. Medical information will only be released when and if prescribed by law and/or at the written request of the student.

Name (Last, First):	**Date of birth (MM/DD/YYYY:**	**Class of:**
Telephone number:	**E-mail address:**	**Prefer Gender Identity:**

Please answer the following questions:		
General health		
1. In the past year, have you developed any health concerns that you have not yet had evaluated?	**Yes** ☐	**No**☐
2a. In the past year, have you developed any medical issue (e.g. chronic illness) or had any surgical intervention that impacts your ability to safely or productively engage in your educational experiences?	**Yes** ☐	**No**☐
2b. If yes, have you received or are you receiving ongoing medical care?	**Yes** ☐	**No**☐
3a. Have you been concerned about your use of alcohol or non-prescription drugs?	**Yes** ☐	**No**☐
3b. Would you like to talk confidentially to someone about it?	**Yes** ☐	**No**☐
4a. Are you feeling down, depressed or anxious in a way that is impairing your ability to engage fully in your educational activities?	**Yes** ☐	**No**☐
4b. Would you like to talk confidentially to someone about it?	**Yes** ☐	**No**☐
5. Would you like to speak with a student health doctor regarding any health related concern?	**Yes** ☐	**No**☐
Exposures		
1a. In the past year, have you had any blood or body fluid exposure (ex. needle stick, splash injury etc.)?	**Yes** ☐	**No**☐
1b. Did you report it?	**Yes** ☐	**No**☐
2. Do you directly handle or transport lab animals at work?	**Yes** ☐	**No**☐
Vaccines		
If you have received a COVID Vaccine: Manufacturer: _____ [] dose 1 date: _____ [] dose 2 date: _____ If not, would you like receive the Covid vaccine?	**Yes** ☐	**No**☐
Preventive Health		
1. Would you like information to help you stop smoking?	**Yes** ☐	**No**☐
2. If applicable, have you had a cervical PAP smear within the past 3 years?	**Yes** ☐	**No**☐
2a. If not, would you like to have this done at Student Health?	**Yes** ☐	**No**☐

Student's e-signature (DO NOT type your name**)**	**Today's date:**

Student Health Provider's name and e-signature. By signing below, I attest that the student above is medically cleared.	**Today's date:**