Icahn School of Medicine at Mount Sinai

Student Health Center
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574
Telephone: (212) 241-6023
E-mail: studenthealth@mssm.edu

Student Health Form

Section A: To Be Completed By Student			
Name (First, Middle, Last)	**Date of Birth (MM/DD/YY)**	**Telephone**	**E-mail address**
Preferred Gender Pronoun	**Sex at Birth**	**Gender Identity**	**Program accepted into:**

Section B: To Be Completed By Provider	
Allergies and reactions	
Past medical history	
Past surgical history	
Hospitalizations	
Mental health	
Medications and dosages	
Family history	

PHYSICAL EXAM

Blood pressure: _____ HR: _____ WT: _____ HT: _____

		Normal	**Significant findings**
General		☐	
HEENT		☐	
Heart		☐	
Lungs		☐	
Abdomen		☐	
Back		☐	
Extremities		☐	
Skin		☐	
Neurologic		☐	
If applicable, date of last cervical PAP smear		☐	

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Tuberculosis Screening

History of BCG vaccine: Yes ☐ No☐
Please complete one of following ::

1) PPD plant: _____ PPD read: _____ Result: _____ mm Interpretation: Positive ☐ Negative ☐

OR

2) Interferon-Gamma Release Assay (IGRA) within 6 months of start date ***(Please attach lab report)***
Date: _____ Positive ☐ Negative ☐

If either test is **positive**, or there is a known history of positive TB screen, please include documentation of:

- **Negative chest x-ray** obtained within 6 months of start date ***(attach result)***
- **Dates treated for LTBI: _____**

Vaccinations and Titers :: Please attach supporting documentation

If non-immune by titer, please initiate booster process and document

1) Official documentation of 3 doses of Hepatitis B vaccine **AND** Hepatitis B surface antibody (IGG) titer.
2) Official documentation of 2 doses of Measles, Mumps and Rubella (MMR) vaccine at least one month apart **AND** MMR antibody (IGG) titer.
3) Official documentation of 2 doses of Varicella vaccine at least one month apart **AND** Varicella antibody (IGG) titer.

Mandatory Vaccines	Vaccine date (MM/DD/YYYY)	Vaccine date (MM/DD/YYYY)	Vaccine date (MM/DD/YYYY)	Titer Must attach lab report
Measles, Mumps and Rubella (MMR)	#1	#2		**MMR Antibody (IGG)☐**
Varicella	#1	#2		**Varicella Antibody (IGG)☐**
Hepatitis B	#1	#2	#3	**Hepatitis B Surface Antibody (IGG) ☐**
Hepatitis B (If not immune by titer)	Booster #1	Booster #2	Booster #3	**Manufacturer:**
Tdap (Must be within 10 years)	#1			No titer needed
Recommended Vaccines	**Vaccine date (MM/DD/YYYY)**	**Vaccine date (MM/DD/YYYY)**	**Vaccine date (MM/DD/YYYY)**	
Covid	#1	#2		**Manufacturer:**
Hepatitis A	#1	#2		
Polio	#1	#2	#3	
Meningococcal	#1			
HPV	#1	#2	#3	
Influenza	#1			

Provider's Printed name, title and license number:	**Today's Date:**
Provider's Signature	**Office stamp:**

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