

U MASS LOWELL

STUDENT HEALTH SERVICES

71 Wilder St. Suite 5
Lowell, MA 01854-3091
Tel: (978) 934-4991

HEALTH EXAMINATION REPORT

STUDENTS WHO DO NOT SUBMIT A COMPLETE HEALTH EXAMINATION REPORT AND IMMUNIZATION FORM WILL NOT BE PERMITTED TO REGISTER

With the exception of your Immunization Records, this information is strictly for the use of the Health Center and will not be released to anyone without your knowledge and written consent. Please complete the first **Three** pages of this form prior to going to your health care provider for examination, they need to fill out remainder of form.

Date Form Completed ____ / ____ / ____

Name _____ Last First Middle	UMS # _____
Home Address _____ Street	Birth Date (Mo. Day Yr) ____ / ____ / ____
_____ City State Country Zip Code	Home Telephone Number _____
Birth Place _____	Male <input type="checkbox"/> Female <input type="checkbox"/>

Date Entering UMass Lowell Fall Spring _____ Year Undergraduate Graduate Transfer

Father's Name
(or Guardian) _____
Last First Middle Occupation
(h) _____
(w) _____
Street City State Zip Code Telephone Numbers

Mother's Name
(or Guardian) _____
Last First Middle Occupation
(h) _____
(w) _____
Street City State Zip Code Telephone Numbers

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name
(or Guardian) _____
Last First Middle Occupation
(h) _____
(w) _____
Street City State Zip Code Telephone Numbers

School Insurance Yes No

Other Insurance: _____
Company State Subscriber ID Number Group Number

Family History

	Age	State Of Health	Age at Death	Cause of Death	Have any of your relatives had any of the following:			
					Yes	No	Relationship	
Father					Allergy, asthma, hay fever			
Mother					Cancer			
Brothers					Diabetes			
					Heart Disease			
Sisters					High blood pressure			
					Kidney disease			
Spouse					Neuromuscular disorder			
Children					Tuberculosis			
					Other			

Personal History

Do you have, or have you ever had: (check all that apply) Explain YES answers below.

Head & Nervous System	Neck	Urinary	Allergy
1 <input type="checkbox"/> Frequent headaches	21 <input type="checkbox"/> Thyroid disease	42 <input type="checkbox"/> Bladder infection	61 <input type="checkbox"/> Seasonal
2 <input type="checkbox"/> Migraine	22 <input type="checkbox"/> Enlarged lymph nodes	43 <input type="checkbox"/> Kidney infection/disease	62 <input type="checkbox"/> Hives/rashes
3 <input type="checkbox"/> Severe head injury/concussion	Heart	44 <input type="checkbox"/> Kidney stone	63 <input type="checkbox"/> Food allergy
4 <input type="checkbox"/> Seizures/convulsions	23 <input type="checkbox"/> High blood pressure	Bones, Joints	64 <input type="checkbox"/> Insect bites/bee stings
5 <input type="checkbox"/> Dizzy spells/fainting	24 <input type="checkbox"/> Heart murmur/click		65 <input type="checkbox"/> Drug allergy (please list below)
6 <input type="checkbox"/> Insomnia	25 <input type="checkbox"/> Palpitations	45 <input type="checkbox"/> Fractures or dislocations	
7 <input type="checkbox"/> Recurrent anxiety	Lungs	46 <input type="checkbox"/> Shoulder Problems	66 <input type="checkbox"/> Anaphylaxis
8 <input type="checkbox"/> Recurrent depression		26 <input type="checkbox"/> Asthma	47 <input type="checkbox"/> Deformity
Eyes, Ears, Nose, Throat	27 <input type="checkbox"/> Bronchitis	48 <input type="checkbox"/> Paralysis or polio	Other
9 <input type="checkbox"/> Wear glasses/contact lenses	28 <input type="checkbox"/> Pneumothorax	49 <input type="checkbox"/> Arthritis	67 <input type="checkbox"/> Tumor/cancer
10 <input type="checkbox"/> Blindness	29 <input type="checkbox"/> Pneumonia	50 <input type="checkbox"/> Back problems	68 <input type="checkbox"/> Sexually transmitted disease
11 <input type="checkbox"/> Injury/disease	30 <input type="checkbox"/> Pleurisy	51 <input type="checkbox"/> Knee or ankle problem	69 <input type="checkbox"/> Anemia
12 <input type="checkbox"/> Double vision		Infectious Diseases	70 <input type="checkbox"/> High cholesterol
13 <input type="checkbox"/> Deafness/hearing aid	Digestive		52 <input type="checkbox"/> Mononucleosis
14 <input type="checkbox"/> Perforated eardrum	31 <input type="checkbox"/> Ulcers	53 <input type="checkbox"/> Measles (Rubeola)	72 <input type="checkbox"/> Eating Disorder
15 <input type="checkbox"/> Repeated ear infections	32 <input type="checkbox"/> Constipation	54 <input type="checkbox"/> Mumps	73 <input type="checkbox"/> Following any special diet
16 <input type="checkbox"/> Sinus trouble	33 <input type="checkbox"/> Chronic abdominal pain	55 <input type="checkbox"/> German measles (Rubella)	Past Illnesses
17 <input type="checkbox"/> Repeated nose bleeds	34 <input type="checkbox"/> Diarrhea, chronic/recurrent	56 <input type="checkbox"/> Chicken Pox (Varicella)	
18 <input type="checkbox"/> Strep throat	35 <input type="checkbox"/> Colitis, Ilietis	57 <input type="checkbox"/> Rheumatic fever	75 <input type="checkbox"/> Operations
19 <input type="checkbox"/> Tonsils/adenoids removed	36 <input type="checkbox"/> Gall stones	58 <input type="checkbox"/> Malaria	76 <input type="checkbox"/> Serious illnesses
	37 <input type="checkbox"/> Hepatitis/jaundice	59 <input type="checkbox"/> Meningitis	77 <input type="checkbox"/> Serious injuries/accidents
Dental	38 <input type="checkbox"/> Appendectomy	60 <input type="checkbox"/> TB or positive skin test	78 <input type="checkbox"/> Emotional problems
20 <input type="checkbox"/> Bleeding gums/gum disease	39 <input type="checkbox"/> Hemorrhoids		79 <input type="checkbox"/> Psychological treatment
	40 <input type="checkbox"/> Irritable bowel		80 <input type="checkbox"/> Psychiatric treatment
	41 <input type="checkbox"/> Sudden weight change		

Identify YES answers by number. Provide details, including dates:
