Stony Brook Medicine

New Dental Student Health Form

Fax/Mail to Stony Brook Preventive Medicine Services
181 N. Belle Mead Rd. Ste. 2, East Setauket, NY 11733
Ph: (631) 444-6250 Fax: (631) 444-6665

Name		**DOB_____/_____/_____**	**Best Phone:**
Class of	**Home Address:**		
Email Address:		**Emergency Contact: (Name and Phone)**	

Medical History: Have you ever had any of the following?

Infectious Diseases	Yes	No	Dates
Chicken Pox or Shingles			
Tuberculosis or positive IGRA or PPD test			
Other infectious disease:			
Respiratory/Lungs			
Chronic Bronchitis/Emphysema/COPD			
Asthma/Wheezing			
Asbestosis, Silicosis, Pneumoconiosis			
Pneumonia			
Pneumothorax (collapsed lung)			
Broken ribs or chest injury/surgery			
Coughing up phlegm or blood			
Shortness of breath or chest tightness			
Cardiovascular/Heart			
Heart Attack			
Chest pain/Angina			
Heart failure			
Irregular heart rhythm or palpitations			
High blood pressure			
Edema (swelling of legs/feet)			
Stroke			
Neurologic and Mood			
Seizures or Epilepsy			
Numbness, weakness or paralysis of arms or legs			
Head injury or concussion			
Severe headaches or migraines			
Dizziness or fainting spells			
Other neurologic disorder			
Sleep apnea or other sleeping disorder			
Claustrophobia or anxiety			
Depression, PTSD or other mood disorder			
High stress level			
Reproductive			
Difficulty conceiving			
Current pregnancy			
History of miscarriage/abnormal pregnancy			
Surgeries or Hospitalizations			
Reason:			

Gastrointestinal and Kidney	Yes	No	Dates
Stomach or intestinal problem			
Nausea/vomiting or abdominal pain			
Blood in stool			
Hepatitis or other liver disease			
Kidney disease or kidney stones			
Hernia			
Blood in urine			
Skin, Endocrine, Severe Allergic Reaction			
Chronic rash, eczema, or dermatitis			
Skin sensitivity or other skin problem			
Unusual tiredness or fatigue			
Heat/cold sensitivity or excessive thirst			
Diabetes			
Thyroid or other endocrine problem			
Allergic reactions that affect breathing			
Ears, Eyes, Nose, Throat			
Wear glasses or contacts			
Blurred vision or other vision loss			
Itchy/Watery eyes or eye pain			
Eye injury or disorder (e.g. glaucoma, macular degeneration, cataracts, etc.)			
Color blindness			
Hearing loss or tinnitus (ringing in ears)			
Dental problems			
Frequent sneezing or nasal discharge			
Trouble smelling odors			
Musculoskeletal			
Back or neck injury/pain			
Arthritis/gout			
Muscle pain			
Other bone/joint problem:			
Blood/Immune System/Cancer			
Easy bruising/bleeding			
Anemia			
Enlarged lymph nodes or glands			
Cancer			
Immune system disorder			
Bleeding or clotting disorder			

Please provide details, including dates, for any items marked yes above. Please note any other medical conditions not listed.

_____

_____

_____

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Medications: Please list your current medications (prescription and over the counter, including vitamins/supplements):

_____
_____
_____
_____

Allergies: please specify	**Yes**	**No**
Medication allergies:		
Latex		
Other (e.g. foods, animals, etc.):		
Social History	**Yes**	**No**
Alcohol Use (Circle # of Drinks per Week): None 1 to 5 6 to 14 15 or more		
Tobacco Use (Circle one): Never Former Current (specify #packs/day and #years):		
Do you use any other substances or recreational/street drugs?		
Have you ever received treatment for substance use or abuse?		
Education and Additional History	**Yes**	**No**
Has your physical activity been restricted or your education interrupted for medical reasons in the past 5 years?		
Have you had difficulty with school, studies, or teachers?		
Have you received treatment or counseling for an emotional or psychiatric condition/problem?		
Have you had any illness, injury or hospitalization other than already noted?		
Have you been rejected or discharged from military services because of physical, emotional or other reasons?		

I certify that the above is true and correct to the best of my knowledge.

Patient Signature: _____ **Date:** _____

PART 2: TO BE COMPLETED BY HEALTHCARE PROVIDER

Please review student's history in Part 1 and complete Part 2 below. This student has been admitted to Stony Brook School of Dental Medicine. Information you provide is confidential and will only be used as background to provide healthcare, if necessary, while student is enrolled. Personal medical information will not be released to anyone without the student's knowledge and consent.

REQUIRED IMMUNIZATIONS: OFFICIAL COPIES OF VACCINE RECORDS AND LAB REPORTS REQUIRED!

Mumps, Measles, Rubella	**Date 1**	**Date 2**
List 2 dates of MMR Vaccine (attach copy of official vaccine record or office record if available)		
List any booster doses for mumps, measles, or rubella vaccine		
Measles antibody titer (lab report required, please attach)		
Mumps titer (lab report required, please attach)		
Rubella titer (lab report required, please attach)		

Hepatitis B	**Date 1**	**Date 2**	**Date 3**
List dates of THREE doses of Hepatitis B vaccine and attach copy of official vaccine record OR student may sign Hep B vaccine declination			
Hepatitis B surface antibody titer (lab report required, please attach): (Titer required even if student declines Hep B vaccination)			

Varicella	**Date 1**	**Date 2**
If negative varicella titer, list 2 dates of varicella vaccine (attach copy of official vaccine record)		
Varicella antibody titer (lab report required, please attach):		

Tetanus	**Date**
List date of tetanus vaccine within past 10 years (attach copy of vaccine record)	

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TUBERCULOSIS SCREENING: To be completed by Healthcare Provider	
If student has history of POSITIVE Tb screening test:	**Date**
Date of positive PPD or Quantiferon:	
Date of chest x-ray (must attach x-ray report)	
If treated, please specify dates and medication(s):	

If student has NO history of positive Tb screening test, a 2-step PPD test is required (or IGRA test within 3 months)

Date Placed:_____/_____/_____ Manuf:_____ Lot #:_____ Exp Date:_____/_____/_____

Date Read: _____/_____/_____ Result: Neg _____mm Pos_____mm

Signature: _____ Print Name:_____ License #:_____

Date Placed:_____/_____/_____ Manuf:_____ Lot #:_____ Exp Date:_____/_____/_____

Date Read: _____/_____/_____ Result: Neg _____mm Pos_____mm

Signature: _____ Print Name:_____ License #:_____

OR ☐ **Lab report** of IGRA test (Quantiferon, T-spot, etc.) within 3 months of enrollment is attached in place of 2-step PPD

PHYSICAL EXAMINATION

Vitals: Ht: Wt: BP: Pulse: Vision: R 20/___ L 20/___ B 20/___ Corr? Y / N

	Normal	**Abnormal**		**Normal**	**Abnormal**
Head, Ears, Nose, Throat			Abdominal		
Eyes			Genitourinary		
Neck-Thyroid			Musculoskeletal		
Respiratory			Skin/Endocrine		
Cardiovascular			Neuro/Psychiatric		

Please describe any abnormalities on physical exam or history:

Questions for Healthcare Provider	**Yes**	**No**
To the best of your knowledge, is this person free from physical or mental impairments, including alcohol or drug dependency?		
Is this person free from any activity limitations or needed accommodations? If not, please note below:		

How long and in what capacity have you known this student?

After physical examination and review of medical history, immunization history and TB screening, I find this individual to be free from health impairment which might interfere with the performance of his/her duties as per NYS Health Code (Title 10, Section 405.3) and Stony Brook School of Dental Medicine policy.

Examining Practitioner's Signature: _____ **Date:**_____

Printed Name: _____ **License # and State:** _____

Address:_____ **Phone:** _____

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