

UMDNJ/Student Health Services
90 Bergen Street
DOC Suite 1750
Newark, NJ 07103-2499
Phone: (973) 972-7687
Fax: (973) 972-0018

School: NJMS _____ NJDS _____ GSBS _____ SPH _____ SHRP _____ VISITING _____ : Program _____ Grad. Year _____

Name _____ Social Security Number _____

Home Address _____ Home Phone _____

Emergency Contact _____ Phone _____

HISTORY

ALLERGIES: seasonal, medications, etc.: _____

CURRENT MEDICATIONS, SUPPLEMENTS: _____
 (please list)

PAST SURGERIES: None YES(List by date with age):

ACCIDENTS: No injuries of consequence YES(List by date with age):

PAST ILLNESSES: No serious past illnesses YES(List by date with age):

HOSPITALIZATIONS: (List by date with reason):

FAMILY HISTORY: If any of the following run in your family, check appropriate block: Allergies Cancer
 Tuberculosis Diabetes Heart Disease Strokes Hypertension Depression

SOCIAL HISTORY: Smoker: Now In past Never **Alcohol:** YES NO **Other drugs:** YES NO

REVIEW OF SYMPTOMS: Place a check mark in the appropriate blocks in the following lists of current or recent symptoms

<p>1. HEAD AND NECK</p> <table border="0"> <tr> <td>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Ringing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Chronic nose obstruction <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Failing vision <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Pain in ears <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Eye pain <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Double vision <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Discharge from ear. <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Teeth problems <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>See "floating lights" <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Repeated nosebleeds <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Severe hearing loss <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Swellings in neck <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> <td></td> </tr> </table>	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Ringing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic nose obstruction <input type="checkbox"/> Yes <input type="checkbox"/> No	Failing vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in ears <input type="checkbox"/> Yes <input type="checkbox"/> No	Eye pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Double vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge from ear. <input type="checkbox"/> Yes <input type="checkbox"/> No	Teeth problems <input type="checkbox"/> Yes <input type="checkbox"/> No	See "floating lights" <input type="checkbox"/> Yes <input type="checkbox"/> No	Repeated nosebleeds <input type="checkbox"/> Yes <input type="checkbox"/> No	Severe hearing loss <input type="checkbox"/> Yes <input type="checkbox"/> No	Swellings in neck <input type="checkbox"/> Yes <input type="checkbox"/> No			<p>5. URINARY TRACT</p> <table border="0"> <tr> <td>Frequent urination <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Frequent night urination .. <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Passed stones <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Hard to start urinary flow . <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Pain with urination <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Scanty urination <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Leakage of urine <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> </tr> </table>	Frequent urination <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent night urination .. <input type="checkbox"/> Yes <input type="checkbox"/> No	Passed stones <input type="checkbox"/> Yes <input type="checkbox"/> No	Hard to start urinary flow . <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain with urination <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No	Scanty urination <input type="checkbox"/> Yes <input type="checkbox"/> No	Leakage of urine <input type="checkbox"/> Yes <input type="checkbox"/> No	
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Provider: For Comments On Any Significant History Use the Space Below

UMDNJ STUDENT HEALTH SERVICES PHYSICAL EXAMINATION

Name _____ Age _____ Today's Date _____
Date of Birth _____

BP	Height	Weight
----	--------	--------

- NORMAL FINDINGS (No Mark = Not Examined)**
 ABNORMAL FINDINGS (describe at right)

General Appearance

- General Health Body Build
 Apparent Age Posture

Skin

- Texture No Skin Lesions
 Turgor Nails

Head and Neck

- Scalp Fundi Pharynx
 Ears Nose Sinuses
 Carotids Tongue Thyroid
 PERLA/EOMI Teeth No Adenopathy

Thorax/Breast

- CHEST No Deformity No Masses Excursion
- HEART RRR No S3 or S4
 No Murmurs PMI not displaced
 No Thrills/Heaves No Ectopic beats
- LUNGS No Crackles No Wheezes
- BREAST No Masses No Tenderness SBE taught

Abdomen

- No Tenderness No Masses No HSM Sounds X 4
 No Hernia No Inguinal Nodes No Scars No Bruits

Female Genital (Recommended)

- Vulva Uterine Shape/Size _____ Adnexa
 Vagina Pap Done _____ Cervix

Male Genital

- Penis Testes No Hernia
 Uncir/Circ Scrotum No Masses

Rectal (Recommend over age 40)

- No Masses No Hemorrhoids
 No Stool Blood Prostate

Musculoskeletal

- EXTREMITIES No Clubbing No Swelling Pulses
 ROM No Deformities No Edema
- BACK No Curvatures ROM No Tenderness

Neurological

- Cranial Nerves Sensory Exam Deep Tendon Reflexes
 No Weakness Gait Romberg Coordination

Mental Status

- Orientation Cognition Mood Language
 Memory Judgment Level of Consciousness Behavior

Vision **Color Blind** No Yes _____
Without Correction **With Correction**

Far R 20/____ L 20/____ Far R 20/____ L 20/____

Near R 20/____ L 20/____ Near R 20/____ L 20/____

Health Care Provider
Name _____

Address _____

Phone _____

Signature _____

DEAR DOCTOR:

The **2 STEP PPD** is a policy requirement. It consists of two PPD tests placed approximately **1-3 weeks apart**. Each test must be read 48-72 hours after placement.

The only exemption is when a student **HAS** a previously recorded negative PPD within the past 12 months documented in your office records and the student tests negative to the first PPD placed within 3 months prior to matriculation. We ask that you send dates and measured results of both tests to UMDNJ.

HISTORY OF BCG DOES NOT NEGATE THE ABOVE REQUIREMENT

Any questions, please call me.

Dr. Winthrop Dillaway
973-972-8219

MENINGOCOCCAL VACCINE

WHAT YOU NEED TO KNOW

1 What is meningococcal disease?

Meningococcal disease is a serious illness, caused by a bacteria. It is the leading cause of bacterial meningitis in children 2-18 years old in the United States. Meningitis is an infection of the brain and spinal cord coverings and is characterized by sudden onset of fever, intense headache, nausea and vomiting, stiff neck and frequently a specific type of rash. This disease is transmitted by respiratory droplet.

About 2,600 people get meningococcal disease each year in the U.S. 10-15% of these people die, in spite of treatment with antibiotics. Of those who live, some may become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age, and in people with certain medical conditions. College freshmen, particularly those who live in dormitories, have a slightly increased risk of getting meningococcal disease.

The risk of meningococcal disease among non-freshman college students is similar to that for the general population.

Meningococcal vaccine can prevent 2 of the 3 important types of meningococcal disease in older children and adults. Meningococcal vaccine is not effective in preventing all types of the disease. But it does help to protect many people who might become sick if they don't get the vaccine.

Drugs such as penicillin can be used to treat meningococcal infection. Still, about 1 out of every ten people who get the disease dies from it, and many others are affected for life. This is why it is important that people with the highest risk for meningococcal disease get the vaccine.

2 Who should get meningococcal vaccine and when?

Meningococcal vaccine is not routinely recommended for most people. People who *should* get the vaccine include:

- U.S. Military recruits
- People who might be affected during an outbreak of certain types of meningococcal disease.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as West Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has terminal complement component deficiency (an immune system disorder).

The vaccine should also be *considered* for:

- Some laboratory workers who are routinely exposed to the meningococcal bacteria.

The vaccine may also be given to college students who choose to be vaccinated. College freshmen, especially those who live in dormitories, and their parents should discuss the risks and benefits of vaccination with their health care providers.

Meningococcal vaccine is usually not recommended for children under two years of age. But under special circumstances it may be given to infants as young as 3 months (the vaccine does not work as well in very young children). Ask your health care provider for details.

How many doses?

- For people 2 years of age and over: 1 dose (Sometimes an additional dose is recommended for people who continue to be at high risk. Ask your provider.)
- For children 3 months to 2 years of age who need the vaccine: 2 doses, 3 months apart

3 Some people should not get meningococcal vaccine or should wait

People should not get meningococcal vaccine if they have ever had a serious allergic reaction to a previous dose of the vaccine.

People who are mildly ill at the time the shot is scheduled can still get meningococcal vaccine. People with moderate or severe illnesses should usually wait until they recover. Your provider can advise you.

Meningococcal vaccine may be given to pregnant women.

4 What are the risks from meningococcal vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of the meningococcal vaccine causing serious harm, or death, is extremely small.

Getting meningococcal vaccine is much safer than getting the disease.

Mild problems

Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days.

A small percentage of people who receive the vaccine develop a fever.

5 What if there is a serious reaction?

What should I look for?

Look for any unusual condition, such as a severe allergic reaction, high fever, or unusual behavior. If a serious allergic reaction occurred, it would happen within a few minutes to a few hours after the shot. Signs of a serious allergic reaction can include difficulty breathing, weakness, hoarseness or wheezing, a fast heart beat, hives, dizziness, paleness, or swelling of the throat.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your health care provider to file a Vaccine Adverse Events Reporting System (VAERS) form, or call VAERS yourself at 1-800-822-7967.

6 How can I learn more?

- Ask your doctor or nurse or check with the Student Health Service on your campus.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-2522** (English)
 - Call **1-800-232-0233** (Español)
 - Visit the National Immunization Program's website at **<http://www.cdc.gov/nip>**
 - Visit the National Center for Infectious Disease's meningococcal disease website at **http://www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm**

Adapted from CDC
Vaccine Information Statement
Meningococcal (3/31/2000)

**U.S. DEPARTMENT OF HEALTH &
HUMAN SERVICES**
Centers for Disease Control and Prevention
National Immunization Program

University of Medicine and Dentistry of New Jersey

Meningococcal Meningitis Response Form

Student Name: _____

Student Date of Birth: _____

UMDNJ School: GSBS NJDS NJMS RWJMS SHRP
 SN SOM SPH OTHER

Campus: Camden Newark Piscataway/New Brunswick
 Scotch Plains Stratford Other: _____

Meningitis Information

I have received information about the nature of meningococcal meningitis disease, disease prevention and treatment, and the availability of a meningococcal vaccine to prevent disease.

Yes() No()

Meningococcal Vaccine

Check one below:

() I have already received the meningococcal vaccine (/)
Date

() I have decided not to receive the meningococcal vaccine.

() I plan to receive the meningococcal vaccine in the future.

() I am undecided about receiving the meningococcal vaccine.

Student signature: _____ Date: _____

* This form shall become part of the student health record and is required by New Jersey law, P.L. 2000c.25.

