



**Lincoln University Health Services  
Health History & Physical Form**

**\*MANDATORY\*** – All entering students **MUST** have a completed Personal Health History & Physical on file (incoming freshman, transfer students, and re-admits). Please complete this page before going to your physician for your examination. This information is strictly for Health Services use and will not be released without your knowledge and/or consent.

LAST NAME (PLEASE PRINT LEGIBLY)      FIRST NAME      MIDDLE INITIAL      COLLEGE ID NUMBER      GENDER

HOME ADDRESS      CITY OR TOWN      STATE      ZIP CODE      DATE OF BIRTH

STUDENT'S CELL PHONE NUMBER      STUDENT'S HOME PHONE NUMBER      SEMESTER ENTERING (FALL OR SPRING)      YEAR

EMERGENCY CONTACT PERSON      RELATIONSHIP TO STUDENT      HOME PHONE NUMBER      CELL PHONE NUMBER      WORK PHONE NUMBER

**DOES YOUR RELIGION PROHIBIT ANY TYPE OF MEDICAL TREATMENT?**       YES  NO

**Family History** (The following questions relate to Parents, Grandparents, and Siblings)

	Age	Condition of Health	Occupation	Age at Death	Cause of Death		Yes	No	Relationship to Student
Father						Tuberculosis			
Mother						Diabetes			
Bro/Sis						Kidney Disease			
Bro/Sis						Arthritis			
Bro/Sis						Stomach Disease			
Bro/Sis						Asthma, Hay Fever			
Bro/Sis						Epilepsy, Convulsions			

**PERSONAL HEALTH HISTORY** (Please answer all questions; comment on all positive answers on a separate sheet of paper)

HAVE YOU HAD (Please ✓)	Y/N	Y/N	Y/N	Y/N
Scarlet Fever		Insomnia		Seasonal Allergies
Measles/ Rubeola		Frequent Anxiety		Pain and/or Pressure in Chest
German Measles/Rubella		Frequent Depression		Chronic Cough
Mumps		Worry or Nervousness		Heart Palpitations
Chicken Pox		Recurrent Headaches		High or Low Blood Pressure
Malaria		Recurrent Colds		Rheumatic Fever or Heart Murmur
Gum and/or Tooth Trouble		Tuberculosis		Disease or Injury of Joints
Hay Fever or Sinusitis				Back Problems
Eye Trouble		Shortness of Breath		Tumor, Cancer, or Cyst
Ear, Nose, Throat Trouble		Asthma		Jaundice
Surgery:		Inhaler and/or Nebulizer Use		Seizure, Epilepsy
Appendectomy		Name of Med		Anemia
Tonsillectomy				Sickle Cell
Hernia Repair		How Often Used		
Any Other Surgery				

**DO YOU HAVE ANY DRUG OR FOOD ALLERGIES? (example- penicillin, sulfonamides, etc.)** If, so to what?

	YES/NO
Has your physical activity been restricted during the past five years? (If yes, give reasons and duration)	
Have you had difficulty with school, studies, or teachers? (If yes, give details)	
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problems? (If yes, give details)	
Have you had any illness or injury or been hospitalized other than already noted? (If yes, give details)	
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years other than routine check-ups?	

STUDENT'S SIGNATURE (IF STUDENT IS A MINOR, PARENT OR GUARDIAN SIGNATURE IS REQUIRED)

DATE

**Lincoln University Health Services  
Physical Examination Form**

**To The Examining Physician:**

Please review the student's health history and complete the physical examination form. Please comment on all positive answers. The information supplied will be used for providing health care, if this is necessary. This information is strictly for the use of the Health Services Office and will not be released without student consent.

Failure to complete and return this form will delay registration. Return of completed form is MANDATORY for ALL entering students.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Gender \_\_\_\_\_  
Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Vision \_\_\_\_\_ (Right Eye) \_\_\_\_\_ (Left Eye) Semester Entering:  Fall or  Spring Year \_\_\_\_\_

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**MANDATORY VACCINES:**

1. Tuberculosis (Testing required within one year prior of admission) Date Administered: \_\_\_\_\_ Reading date & results: \_\_\_\_\_  
**(If positive result, must have a negative chest x-ray report attached. If QuantIFERON Gold test is done, must attach report) negative or positive**
2. DT or Tdap (Required within ten years of admission) Date: \_\_\_\_\_
3. MMR Date: \_\_\_\_\_ Date: \_\_\_\_\_ or Titer Report: \_\_\_\_\_
4. Varicella (Chicken Pox) Date: \_\_\_\_\_ Date: \_\_\_\_\_ or Titer Report: \_\_\_\_\_  
**(\*Must have two vaccine dates or positive IGG report attached; history of having disease is not acceptable)**
5. Menactra (Meningitis) Date: \_\_\_\_\_ (Not required for commuters)

**COVID-19 VACCINATION INFORMATION:** Which vaccine did you receive? (circle answer) MODERNA PFIZER JOHNSON & JOHNSON

Date of 1<sup>st</sup> dose: \_\_\_\_\_ Date of 2<sup>nd</sup> dose: \_\_\_\_\_ Booster date: \_\_\_\_\_

\*If you have a documented exemption, please notify the Office of Intuitional Equity to complete their form. [disabilityservices@lincoln.edu](mailto:disabilityservices@lincoln.edu) \*

**RECOMMENDED:** (For students who will possibly be exposed to blood and/or body fluids in a clinical and/or research setting)

Hepatitis B: Dose 1: \_\_\_\_\_ Dose 2: \_\_\_\_\_ Dose 3: \_\_\_\_\_  
Polio: Date Series Completed: \_\_\_\_\_ Date of last booster: \_\_\_\_\_  
Gardasil: Dose 1: \_\_\_\_\_ Dose 2: \_\_\_\_\_ Dose 3: \_\_\_\_\_  
Influenza: Last dose received: \_\_\_\_\_

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**URINALYSIS OR URINE DIP STICK:** Glucose: \_\_\_\_\_ Ketones: \_\_\_\_\_ pH: \_\_\_\_\_  
Leukocytes: \_\_\_\_\_ Nitrites: \_\_\_\_\_ Blood: \_\_\_\_\_  
If Indicated (Serum): Hgb/Hct: \_\_\_\_\_ Glucose: \_\_\_\_\_ Na+: \_\_\_\_\_ K+: \_\_\_\_\_

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Are there any abnormalities of the following?  Head, Ears, Nose or Throat  Respiratory  Cardiovascular  Gastrointestinal  
 Hernia  Eyes  Genitourinary  Musculoskeletal  Metabolic/Endocrine  Neuropsychiatric  Skin

Is there loss or seriously impaired function of any paired organ?  No  Yes \_\_\_\_\_

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Current Medications: \_\_\_\_\_ Physical Restrictions: \_\_\_\_\_

Do you have any recommendations regarding the care of this student? \_\_\_\_\_

Is the student currently under treatment for any medical or emotional condition? \_\_\_\_\_

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Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Print Last Name: \_\_\_\_\_ Ofc Number \_\_\_\_\_

Return completed forms to:  
Lincoln University Health Services  
1570 Baltimore Pike  
Wellness Center, Suite 100  
Lincoln University, PA 19352  
Ofc: 484-365-7338 Fax: 484-365-7287  
[Healthservices@lincoln.edu](mailto:Healthservices@lincoln.edu)