NEWTON-WELLESLEY HOSPITAL
2014 Washington Street
Newton, Massachusetts 02462

PATIENT IDENTIFICATION AREA

Health Services at Wellesley College provided by Newton-Wellesley Collegiate Health

NEW STUDENT PROVIDER MEDICAL HISTORY AND EXAM

To be completed by primary care provider

Student Name _____

DOB (mm/dd/yy)_____ Anticipated Graduation Date_____
For how long have you known the student? _____

MEDICAL HISTORY: please describe significant diagnoses, chronic illnesses, injuries (use back for more space if needed)

☐ **Patient has no significant medical history**

Active Issues/Treatment Plan:

_____ Treatment Plan: _____

_____ Treatment Plan: _____

_____ Treatment Plan: _____

_____ Treatment Plan: _____

Past Issues:

_____ Date Resolved _____

_____ Date Resolved _____

_____ Date Resolved _____

Please List any Surgeries (Date):
Medical Hospitalizations (Date/Reason):
Does the patient currently see any medical specialists: **Yes / No** o Name/Specialty

Health Services provided by Newton-Wellesley Collegiate Health * 106 Central St. Wellesley, MA
Tel 781-283-2810 * Fax 781-283-3693

059753 5/2020

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BEHAVIORAL HEALTH HISTORY: please comment on any psychiatric diagnosis or emotional issues that health services should be aware of (use back for more space if needed)

☐ **Patient has no significant mental health history**

Active Issues/Treatment Plan:

_____ Treatment Plan: _____

_____ Treatment Plan: _____

_____ Treatment Plan: _____

_____ Treatment Plan: _____

Past Issues:

_____ Date Resolved _____

_____ Date Resolved _____

_____ Date Resolved _____

Psychiatric Hospitalizations (Date/Reason):
Does the patient currently see any medical specialists: **Yes / No** o Name/Specialty
Does the patient have a current or past h/o eating disorder: **Yes / No** o Diagnosis o Treatment History o Current Treatment Plan

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Current Medications/Dosages:

_____

_____

_____

_____

Known Allergies (include medications, foods, substances) :

_____

_____

PHYSICAL EXAMINATION: must be completed within 1 year of date on form
(6 months for NCAA athletes)

Height: _____ Weight: _____ BMI :_____ Blood pressure: _____ Pulse: _____

	Normal	Abnormal- Describe Abnormalities
Head, Nose Sinuses		
Mouth, Teeth, Gums		
Ears, Hearing		
Throat, thyroid		
Lungs		
Heart		
Abdomen		
Skin		
Lymph Nodes		
Extremities, Joints		
Neurologic		
Breasts/Pelvic (if indicated)		

Does the student intend to participate in intercollegiate athletics?
Yes / No Team _____

Recommendation for Physical Education and Activity:

☐ **UNLIMITED** ☐ **LIMITED (explain)**_____

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Please comment on any additional concerns that health services should be aware of (use back if more space needed).

Provider's Name_____**(M.D./P.A./N.P.)**

Provider's Signature _____ **Date** _____ **Time** _____

Provider's address, Phone Number, Fax Number: