

USP STUDENT HEALTH OFFICE MEDICAL HISTORY QUESTIONNAIRE

PLEASE COMPLETE BOTH SIDES BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

2009-2010

To the Student: You have been accepted for admission to USP. Information you provide will not be used to influence your situation at the university; it will be used, if necessary, solely as an aide to provide health care. This information is strictly for the use of the Student Health Services and will not be released to anyone without your knowledge and consent. Remember to keep a copy for your records before mailing it to the Student Health Office, University of the Sciences in Philadelphia, 600 S. 43rd Street, Philadelphia, PA 19104-4495.

M
 F

LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX	DATE OF BIRTH
HOME ADDRESS (number and street)		CITY OR TOWN	STATE	ZIP CODE
				HOME TELEPHONE

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP
() DAY TELEPHONE	() EVENING TELEPHONE

LIST OF COLLEGES YOU HAVE ATTENDED, ADDRESSES AND DATES

STUDENT ID NUMBER	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> OTHER	CLASS YOU ARE ENTERING
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FAMILY HISTORY					
	Age	Any Major Medical Problems	Occupation	Age at Death	Cause
Father					
Mother					
Brothers					
Sisters					

Have Any of Your Relatives Ever Had Any of the Following			
	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Cancer (Type)			
Heart Disease			
Bowel/Stomach Disease			
Asthma			
Seizures			
High Blood Pressure			
Stroke			
Blood Disease			
Other			

Personal History: PLEASE ANSWER ALL QUESTIONS:

Comment On all Positive Answers in Space Reserved For Remarks or Additional Information.

HAVE YOU HAD?	YES	NO
Measles (Rubeola)		
German Measles (Rubella)		
Mumps		
Chicken Pox		
Malaria		
Gum or Tooth Problems		
Frequent Sinusitis		
Eye Problems		
Ears, Nose, Throat Problems		
Surgery		
Appendectomy		
Tonsillectomy		
Hernia Repair		
Other		
Skin Problems		
Insomnia		
Frequent Anxiety		
Frequent Depression		
Recurrent Headaches		
Significant Head Injury		
Joint Disease or Injury		
Back Problems		

	YES	NO
Tumors, Cysts		
Cancer		
Asthma		
Tuberculosis		
Shortness of Breath		
Chronic Cough		
Frequent Upper Respiratory Infection		
Pain/Pressure in Chest		
Heart Palpitations		
Rheumatic Fever		
Heart Murmur		
Low or High Blood Pressure		
Are You Allergic to:		
Penicillin		
Sulfonamides		
Other Antibiotics		
Vaccines (which)		
Other Medications		
Foods (which)		
Inhalants (which)		
Jaundice		

	YES	NO
Gallbladder Problems		
Diabetes		
Stomach or Intestinal Problems		
Frequent Diarrhea		
Frequent Constipation		
Hernia		
Weight Problems		
Dizziness, Fainting		
Weakness, Paralysis		
Kidney or Urinary Problems		
Seizure Disorder		
Sexually Transmitted Disease		
Females Only - Menstrual History		
Age @ onset		
Length of Period (days)		
Cycle (Start to Start) (days)		
Flow: Heavy-Medium-Light		
Significant Mood Changes		
Cramps/Pain		

MEDICAL HISTORY QUESTIONNAIRE (CONT.)

Yes No

A. Has your physical activity been restricted during the past five years? (Give reasons and durations)		
B. Have you had difficulty with school, studies or teachers? (Give details)		
C. Have you received treatment or counseling for emotional difficulties or any psychological/psychiatric conditions?		
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E. Have you consulted or been treated by clinics, physicians or other practitioners within the past five years? (Other than routine checkups?)		
F. Have you been rejected for or discharged from military service because of physical, emotional or other reasons? (If so, give reasons)		

PLEASE LIST NAMES AND DOSAGES OF ANY MEDICINES, PRESCRIPTIONS OR NON-PRESCRIPTIONS, TAKEN ON A REGULAR OR FAIRLY REGULAR BASIS.

REMARKS OR ADDITIONAL INFORMATION

DO YOU / HAVE YOU	YES	NO
Exercise regularly		
Sleep Well		
Have regular bowel movements		
Ever been treated for alcohol abuse		
Ever been treated for drug abuse		
Participate in sports or have hobbies which give you relaxation		

DO YOU USE	NEVER	OCC.	FREQ.	DAILY
LAXATIVES				
VITAMINS				
TRANQUILIZERS				
SLEEPING PILLS				
APPETITE SUPPRESSANTS OR STIMULANTS				

DO YOU USE	NEVER	OCC.	FREQ.	DAILY
ASPIRIN/TYLENOL				
IBUPROFEN				
COFFEE OR CAFFEINE				
ALCOHOLIC BEVERAGES				
CIGARETTES				
CHEWING TOBACCO				

PHYSICIAN'S HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's Medical History Questionnaire and complete this form. Please comment on all positive answers. The student has been accepted. The information supplied will not affect his/her status. It will be used only as a background for providing health care, if this is necessary. The information is strictly for the use of the Health Services, and will not be released without student consent.

ARE THERE ABNORMALITIES IN THE FOLLOWING SYSTEMS?			
Describe fully. Use additional sheet if needed.			
	Yes	No	Describe
1. Head			
2. Eyes			
3. Ears, Nose, Throat			
4. Neck			
5. Respiratory			
6. Cardiovascular			
7. Gastrointestinal			
8. Genitourinary			
9. Musculoskeletal			
10. Metabolic/Endocrine			
11. Neurologic			
12. Psychiatric			
13. Skin			

Screening Tests:

Blood Pressure _____

Pulse (resting) _____

Height _____

Weight _____

Corrected Vision:

Right 20/ _____ Left 20/ _____

Is there loss or seriously impaired function of any organ? _____ Yes _____ No

Have you any general comments? _____

Recommendation for physical activity (PE, Intramural, ROTC) Unlimited _____ Limited _____ Explain _____

Do you have any recommendation regarding the care of this student? _____ Yes _____ No

Is the patient now under treatment for any medical or emotional condition? _____ Yes _____ No

Student Signature

Physician's Signature (Acknowledge Review)

Date

THIS RECOMMENDED FORM HAS BEEN APPROVED BY THE LIAISON COMMITTEE OF THE AMERICAN COLLEGE HEALTH ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION AND APPROVED BY THE AMERICAN COLLEGE HEALTH ASSOCIATION. IT HAS BEEN UPDATED AND SLIGHTLY REVISED ACCORDING TO THE PARTICULAR NEEDS OF THIS COLLEGE'S STUDENT HEALTH DEPARTMENT.

IMMUNIZATION RECORD

Last Name _____

First Name _____

Student ID Number _____

PART II - TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER.

All information must be in English

The following immunizations are mandatory:

A. TUBERCULOSIS SCREENING

1. Does the student have signs or systems of active tuberculosis disease? Yes ___ No ___
If NO, proceed to 2. If YES, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is the student a member of a high-risk group or is the student entering the health professions? Yes ___ No ___
If NO, stop. If YES, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.
3. Tuberculin Skin Test: Date Given: ___/___/___ Date Read: ___/___/___
MO DAY YR MO DAY YR
Result: _____ (Record actual mm of induration, transverse diameter, if no induration, write "0")
Interpretation (based on mm of induration as well as risk factor): Positive ___ Negative ___
4. Chest x-ray (required if tuberculin skin test is positive) result: Normal ___ Abnormal ___ Date of Chest X-Ray: ___/___/___
MO DAY YR

B. M.M.R. (Measles, Mumps, Rubella)

(Two doses required or individual vaccines as noted below)

1. Dose 1 given at 12 months or later #1 ___/___/___
MO DAY YR
2. Dose 2 given at least 28 days after first dose #2 ___/___/___
MO DAY YR

C. TETANUS-DIPHTHERIA-PERTUSSIS (Primary series with DTaP, DTP, DT or Td and booster must be with the last ten years.)

1. Primary series of four doses with DTaP, DTP, DT or Td:
#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
MO DAY YR MO DAY YR MO DAY YR MO DAY YR
2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient ___/___/___
MO DAY YR
3. Booster: Td within the last ten years ___/___/___
MO DAY YR

D. MENINGITIS

Vaccine **OR** Waiver is required of all University of the Sciences in Philadelphia

Date of Vaccination: _____

Menomune ___/___/___
(Quadrivalent polysaccharide vaccine)

Menactra ___/___/___
(Polysaccharide Diphtheria Toxoid Conjugate Vaccine)

MENINGITIS INFORMATION RESPONSE

Required of all resident students. (Check either #1 or #2)

1. _____ I have had the meningococcal meningitis immunization
2. _____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided that I will NOT obtain immunization against meningococcal meningitis disease.

Signature of Student Required (or Parent/Guardian if Student is under age 18)

E. HEPATITIS B

(All college students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody meets the requirement.)

1. Immunization (Hepatitis B)
a.) Dose #1 ___/___/___ b.) Dose #2 ___/___/___ c.) Dose #3 ___/___/___ Check if Combined Hepatitis A and B Vaccine ___
MO DAY YR MO DAY YR MO DAY YR
2. Hepatitis B surface antibody: Date ___/___/___ Results: Reactive ___ Nonreactive ___
MO DAY YR

IMMUNIZATIONS CONTINUED

Last Name _____

First Name _____

Student ID Number _____

F. POLIO

(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

1. OPV alone (oral Sabin three doses): #1 / / #2 / / #3 / /
MO DAY YR MO DAY YR MO DAY YR
2. IPV/OPV sequential: IPV #1 / / IPV #2 / / OPV #3 / / OPV #4 / /
MO DAY YR MO DAY YR MO DAY YR MO DAY YR
3. IPV alone (injected Salk four doses): #1 / / #2 / / #3 / / #4 / /
MO DAY YR MO DAY YR MO DAY YR MO DAY YR

G. VARICELLA

1. History of Disease Yes _____ No _____ If so, when? _____

OR

2. Varicella antibody: Date / / Results: Reactive _____ Nonreactive _____
MO DAY YR

OR

3. Immunization: Dose #1 / / Dose #2 / /
MO DAY YR MO DAY YR

Optional:

H. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)

(Three doses of vaccine for female college students 11-26 years of age at 0, 2 and 6 month intervals.)

- a.) Dose #1 / / b.) Dose #2 / / c.) Dose #3 / /
MO DAY YR MO DAY YR MO DAY YR

I. HEPATITIS A

- a.) Dose #1 / / b.) Dose #2 / /
MO DAY YR MO DAY YR

2. Immunization (Combined Hepatitis A and B)

- a.) Dose #1 / / b.) Dose #2 / / c.) Dose #3 / /
MO DAY YR MO DAY YR MO DAY YR

J. OTHER If Applicable _____

HEALTH CARE PROVIDER

Name _____

Signature _____

Address _____

Phone Number _____

1 The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/.

2 Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

For more information, see website: www.usp.edu/shac

Please return all information to:

Student Health Office

University of the Sciences in Philadelphia

600 South 43rd Street • Philadelphia, PA 19104-4495