

| | | |
|-----------------------------------|-------|-------|
| FOR US SCIENCES STAFF ONLY | | |
| DATA MISSING | _____ | _____ |
| DATE COMPLETE: | _____ | |

MEDICAL HISTORY QUESTIONNAIRE 2012-2013

INSTRUCTIONS AND INFORMATION for students and their family:

1. The primary purpose of this form is to assure that immunizations are current and that entering students pose no public health problem.
2. A **late fee** of \$25.00 will be charged for failure to submit a fully completed form by the due date.
3. Registration will be withheld until this form is returned with documentation.
4. Information on this form is **CONFIDENTIAL** and solely for the Student Health Office and will not be released without the student's written consent.
5. **Please return all information to:** Student Health Office • University of the Sciences • 600 South 43rd Street • Philadelphia, PA 19104-4495

| | | | | |
|-------------------|--|---|----------|--------------------|
| LAST NAME | FIRST NAME | MIDDLE INITIAL | SEX | DATE OF BIRTH |
| HOME ADDRESS | CITY OR TOWN | STATE | ZIP CODE | STUDENT CELL PHONE |
| STUDENT ID NUMBER | 1 ST 2 ND 3 RD 4 TH 5 TH GR CLASS YEAR | <input type="checkbox"/> PharmD <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> PA <input type="checkbox"/> Other MAJOR | | |

EMERGENCY CONTACT INFORMATION

| | |
|---------------|---------------|
| NAME | RELATIONSHIP |
| () | () |
| DAY TELEPHONE | EVENING PHONE |

FAMILY HISTORY

| | Age | Major Medical Problems | Age at Death | Cause |
|----------|-----|------------------------|--------------|-------|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |

| Have Any of Your Relatives 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 _____ | | | |

Last Name

First Name

Middle Initial

Student ID

PERSONAL HISTORY

PLEASE COMMENT ON ALL POSITIVE ANSWERS IN THE SPACE RESERVED FOR REMARKS OR ADDITIONAL INFORMATION

| HAVE YOU/DO YOU HAVE | 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 | | |
| Weight Problems | | |
| Dizziness, Fainting | | |
| Weakness, Paralysis | | |

| HAVE YOU/DO YOU HAVE | 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 | | |
| Jaundice | | |
| Gallbladder Problems | | |
| Diabetes | | |
| Stomach or Intestinal Problems | | |
| Frequent Diarrhea | | |
| Frequent Constipation | | |
| Hernia | | |
| Kidney or Urinary Problems | | |
| Seizure Disorder | | |
| Sexually Transmitted Disease | | |

| ARE YOU ALLERGIC TO: | YES | NO |
|---|-----|----|
| Penicillin | | |
| Sulfonamides | | |
| Other Antibiotics | | |
| Vaccines | | |
| Other Medications | | |
| Foods | | |
| Inhalants | | |
| Females Only - Menstrual History | | |
| Age @ onset | | |
| Length of Period (days) | | |
| Cycle (Start to Start) (days) | | |
| Flow: Heavy-Medium-Light | | |
| Significant Mood Changes | | |
| Cramps/Pain | | |

| DO YOU/HAVE YOU | YES | NO |
|---|-----|----|
| Exercise regularly | | |
| Sleep Well | | |
| Have regular bowel movements | | |
| Ever been treated for drug 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 | | | | |
| Aspirin/Tylenol or Ibuprofen | | | | |
| Coffee or Caffeine | | | | |
| Alcoholic Beverages | | | | |
| Cigarettes or Chewing Tobacco | | | | |

| | 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: _____

Student Signature

Date

Last Name

First Name

Middle Initial

Student ID

PART II – HEALTH PROFESSIONAL EVALUATION

TO THE HEALTH CARE PROVIDER: Please review the student’s Medical History Questionnaire and complete this form. Please comment on all positive answers. The student has been accepted and 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’s consent.

| ARE THERE ABNORMALITIES IN THE FOLLOWING SYSTEMS? Describe fully. | | | |
|---|-----|----|----------|
| | 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: Height _____ Blood Pressure _____
 Weight _____ Pulse (resting) _____
 Body Mass Index (BMI) _____

Corrected Vision Right 20/_____ Left 20/_____

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

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

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

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

Is the student suitable to provide child care or work in such an environment? Yes _____ No _____

Did this student have any communicable diseases? No _____ Yes _____ Explain _____

HEALTH CARE PROVIDER

Name: _____

Signature: _____

Address: _____

Phone Number: _____

Last Name

First Name

Middle Initial

Student ID

PART III – IMMUNIZATION RECORD

TO BE COMPLETED BY A HEALTH CARE PROVIDER – ALL INFORMATION MUST BE IN ENGLISH

A. HEPATITIS B - Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, **OR** a positive Hepatitis B surface antibody.

1. Immunization #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ Check if Immunization is Combined Hepatitis A and B _____
MO DAY YR MO DAY YR MO DAY YR

OR

2. Hepatitis B surface antibody: Date ____/____/____ Results: Reactive ____ Nonreactive ____
MO DAY YR

B. POLIO - Primary series, doses at least 28 days apart. Three primary series are acceptable. See www.cdc.gov 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

C. TETANUS-DIPHTHERIA-PERTUSSIS

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. Tdap Booster **required**. #1 ____/____/____
MO DAY YR

D. VARICELLA - Two doses of varicella vaccine **OR** serologic evidence of immunity (IgG)

1. Varicella antibody: Date ____/____/____ Results: Reactive ____ Nonreactive ____
MO DAY YR

OR

2. Immunization: #1 Date ____/____/____ #2 Date ____/____/____
MO DAY YR MO DAY YR

E. MEASLES, MUMPS, RUBELLA (M.M.R.) – Two doses required

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

F. MENINGITIS

1. Meningococcal vaccine ____/____/____ Meningococcal Conjugate Booster ____/____/____
(Covering serogroups A, C, Y, and W-135) (Polysaccharide Diphtheria Toxoid Conjugate Vaccine)

OR

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)

G. TUBERCULOSIS SCREENING - Please check www.acha.org or www.cdc.gov for full list of high risk groups.

1. Does the student have signs or symptoms of active tuberculosis disease? Yes ____ No ____
If NO, proceed to 2. If YES, proceed with additional evaluation as in 3 and 4.
2. Is the student a member of a high-risk group? Yes ____ No ____
If NO, stop. If YES, place tuberculin skin test. 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: Positive ____ Negative ____ (based on mm of induration as well as risk factor)
4. Chest X-Ray (required if tuberculin skin test is positive) Date of Chest X-Ray: ____/____/____
Result: Normal ____ Abnormal ____

H. Optional: QUADRIVALENT HUMAN PAPILOMAVIRUS VACCINE (HPV). #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
MO DAY YR MO DAY YR MO DAY YR

Health Care Provider Signature

Date