



**II. FAMILY HISTORY**

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brother/Sister					
Spouse					

Has your father, mother, sister, or brother ever had any of the following?

	Yes	No	Relationship
Stroke/Heart Disease			
Tuberculosis			
Diabetes			
Kidney Disease			
Arthritis			
Stomach Disease			
Chronic Respiratory Disease/Asthma			
Cancer			

**III. PERSONAL HISTORY**

Please answer all questions. Have you ever had or had any of the following?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Significant head injury | <input type="checkbox"/> Infectious mononucleosis       |
| <input type="checkbox"/> Hernia           | <input type="checkbox"/> Heart disease/murmur    | <input type="checkbox"/> High/Low blood pressure        |
| <input type="checkbox"/> Fracture/Disloc. | <input type="checkbox"/> Surgery/Hospitalization | <input type="checkbox"/> Digestive disorders            |
| <input type="checkbox"/> Chicken pox      | <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Freq. Urinary tract infections |
| <input type="checkbox"/> Mumps            | <input type="checkbox"/> German measles          | <input type="checkbox"/> Large weight gain/loss         |
| <input type="checkbox"/> Measles          | <input type="checkbox"/> Eye problems            | <input type="checkbox"/> Fainting spells/dizziness      |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Hepatitis/Jaundice      | <input type="checkbox"/> Sugar/Albumin in urine         |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Tumor/Cancer            | <input type="checkbox"/> Chronic Respiratory Disease    |
| <input type="checkbox"/> Kidney stone     | <input type="checkbox"/> Back problems           | <input type="checkbox"/> Anxiety/Depression             |
| <input type="checkbox"/> Seizures         | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Weakness/Paralysis             |
| <input type="checkbox"/> Insomnia         | <input type="checkbox"/> Menstrual problems      | <input type="checkbox"/> Shortness of Breath            |
| <input type="checkbox"/> Anorexia         | <input type="checkbox"/> Bulimia                 |   |

Please identify any problem or concern that would require ongoing care by the Health Center \_\_\_\_\_

Do you have allergies? (foods, medicines, latex, insects, etc.) \_\_\_\_\_

Do you take medications? No \_\_\_ Yes \_\_\_

Name	Dose & Frequency

Has your physical activity been restricted during the past 5 years? Yes \_\_\_ No \_\_\_

Explain \_\_\_\_\_

Have you had any physical or psychological concerns that may interfere with University success?

Yes\_\_\_ No\_\_\_ Explain\_\_\_\_\_

Have you ever received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? Yes\_\_\_ No\_\_\_

Details\_\_\_\_\_

Have you had any illness or injury or been hospitalized other than already noted? Yes\_\_\_ No\_\_\_

Details\_\_\_\_\_

Smoking history: \_\_\_\_\_ packs per day

Drinking history: \_\_\_\_\_ drinks per week

Disability (optional)

Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration from the University? Describe:

\_\_\_\_\_

I hereby give permission to the university physician or designee to prescribe necessary medication and or perform treatments or procedures necessary in the best interest of my health needs. I understand that my parents or guardians will be notified of any serious illness or injury only at my request.

**STUDENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Parent/guardian signature of a minor student:** \_\_\_\_\_

Part 2

**PHYSICIAN REPORT/COMPLETE PHYSICAL EXAM**

**I. REQUIRED IMMUNIZATIONS**

- |  |        |
|--|--------|
|  | Dates: |
| A. Tdap or other tetanus booster<br>(Within the last 10 years) | _____  |
| B. MMR- 2 doses are required                                   |        |
| Dose 1- Immunized between 15 months-5 years                    | _____  |
| Dose 2- Immunized at 5 years or later                          | _____  |
| OR   |        |
| Measles  |        |
| Had disease, confirmed by office record                        | _____  |
| Has report of immune titer, ATTACH COPY                        | _____  |
| Rubella  |        |
| Has report of immune titer, ATTACH COPY                        | _____  |
| Immunized with vaccine at 15 months or later                   | _____  |
| Mumps  |        |
| Had disease, confirmed by office record                        | _____  |
| Immunized with vaccine at 15 months or later                   | _____  |
| C. Tuberculosis (PPD or IGRA)                                  |        |
| Within 6 months of admission                                   |        |
| Date_____ Result: Positive_____ Negative_____                  |        |
| If positive PPD, recent chest x-ray required- ATTACH COPY:     |        |
| Date _____ Result: Positive_____ Negative_____                 |        |
| Had BCG vaccine: Date_____                                     |        |

- D. Polio  
Complete primary series of polio immunizations Yes\_\_\_ No\_\_\_  
Date of last booster \_\_\_\_\_
- E. Meningitis (MCV4): Date\_\_\_\_\_
- F. Hepatitis B: Dose #1\_\_\_\_\_ Dose #2\_\_\_\_\_ Dose #3\_\_\_\_\_
- G. Varicella (chicken pox): Dose #1\_\_\_\_\_ Dose #2\_\_\_\_\_  
Hx of disease Date:\_\_\_\_\_

**II. PHYSICAL EXAMINATION**

Height\_\_\_\_\_ Weight\_\_\_\_\_ Blood Pressure\_\_\_\_\_ Pulse\_\_\_\_\_

Vision: Uncorrected R\_\_\_\_\_ L\_\_\_\_\_  
Corrected R\_\_\_\_\_ L\_\_\_\_\_

Hearing: R\_\_\_\_\_ L\_\_\_\_\_

Allergies to medication \_\_\_\_\_

	Normal	Abnormal	Comment
HEENT			
Lungs/chest			
Heart (including murmur)			
Abdomen			
Hernia			
Extremities			
Musculoskeletal			
Skin			
Lymph nodes			
Neurological			

Medications: \_\_\_\_\_

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

Recommendations for physical activity (Intramurals, ROTC, Intercollegiate athletics):

Unlimited\_\_\_\_\_ Limited\_\_\_\_\_

Explain \_\_\_\_\_

Is the student now under treatment for any medical or emotional condition?

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

Physician signature\_\_\_\_\_ Date of exam\_\_\_\_\_

Physician name\_\_\_\_\_

Address\_\_\_\_\_

Telephone # \_\_\_\_\_