

EAST STROUDSBURG UNIVERSITY OF PENNSYLVANIA
UNIVERSITY HEALTH SERVICES
REPORT OF MEDICAL HISTORY
TELEPHONE (570) 422-3553
FAX (570) 422-3731

STUDENT:

Please complete report of medical history prior to physical exam. Information supplied will be held in confidence, and will aid in providing health care while you are enrolled.

Attach a copy of both sides of student's health insurance card to this form.

GENDER: Male Female _____
(PRINT) LAST NAME FIRST NAME MIDDLE SOC.SEC.NO. CELL PHONE NO.

HOME ADDRESS (STREET & NUMBER) _____ CITY OR TOWN _____ STATE _____ ZIP CODE _____ DATE OF BIRTH _____

NAME OF PERSON TO CONTACT IN EMERGENCY _____ (AREA CODE) HOME PHONE NO. _____

HOME ADDRESS (STREET & NUMBER) _____ CITY OR TOWN _____ STATE _____ ZIP CODE _____ (AREA CODE) BUS. PHONE NO. _____

HEALTH AND ACCIDENT INSURANCE PROVIDER _____ GROUP NUMBER _____ POLICY NUMBER _____

CITIZENSHIP: U.S. Other CLASS ENTERING: Under Graduate Graduate

FAMILY HISTORY:

	Living	Deceased	Age of Death	Cause	Occupation
Father					
Mother					
Siblings					

HAVE YOUR BLOOD RELATIVES EVER HAD:

	Yes	No		Yes	No		Yes	No
Arthritis			Heart Disease			Seizures/Convulsions		
Asthma			High Blood Pressure			Tuberculosis		
Diabetes			Kidney Disease			Ulcer: Duodenal/Peptic		

HAVE YOU HAD:

	Yes	No		Yes	No		Yes	No
ALLERGIC TO:			German Measles			Tumor/Cyst: Benign		
Penicillin			Measles			Malignant		
Sulfonamide			Rheumatic Fever			Anxiety/Depression		
Other (describe)			Scarlet Fever			Psychiatric		
No known allergy			Jaundice			Alcohol/Drug Dependency		
Arthritis (describe)			Malaria			Eating Disorder		
Asthma (describe)			Mononucleosis			Chest Pain/Pressure		
Digestive Problem (describe)			Urine: Albumin			Dizziness/Fainting		
Head Injury (describe)			Sugar			Recent Gain/Loss of Weight		
High Blood Pressure			Frequency			Weakness/Paralysis		
Heart Disease/Problem (describe)			PROBLEMS: Dental			Sexually Transmitted Disease		
Kidney Disease (describe)			Ear			Hernia		
Diabetes (describe)			Eye			Hives		
Seizures/Convulsions (describe)			Nose/Throat			Shortness of Breath		
Tuberculosis (describe)			Anemia			Other (describe)		
SURGERY: Appendectomy			Headaches					
Hernia Repair			Diarrhea			FEMALES ONLY:		
Tonsillectomy			Back Problems			Excessive Flow		
Other (describe)			Chronic Cough			Irregular Periods		
Chicken Pox			Gallbladder Problems			Severe Cramps		
Mumps								

Instructional Resources Jan 2007

HAS YOUR PHYSICAL ACTIVITY BEEN RESTRICTED IN THE PAST? Yes No (If 'yes' give reasons and duration)

Please attach additional sheet to describe concerns or give remarks.

CONSENT FOR TREATMENT

I certify that the information provided on this Medical History Form is true and complete to the best of my knowledge. I also realize that this information is confidential and for use by the Health Services staff.

I give permission for myself (son/daughter) to be evaluated, diagnosed and treated by University Health Services under the direction of a physician.

It should be understood that under certain circumstances or emergencies, I (son/daughter) may be referred to an area hospital, diagnostic testing facility or medical specialist for evaluation, diagnosis, and/or treatment. **Costs for these services are the responsibility of the student.**

STUDENT SIGNATURE _____

DATE _____

PARENT/LEGAL GUARDIAN SIGNATURE _____

DATE _____

(If student is a minor under 18 years old)

REQUIRED IMMUNIZATIONS

A. TUBERCULOSIS (Test must be done within past year) (Enter Month/Day/Year)

1. <input type="checkbox"/> PPD (Mantoux)	Date given:	Date read:
	_____/_____/_____	_____/_____/_____
	MONTH DAY YEAR	MONTH DAY YEAR
	_____/_____	Results: ____ mm Negative ____ mm Positive
	SITE TIME	
		_____ SIGNATURE OF RN/MD

2. Chest x-ray required for positive PPD (or if PPD not done): _____
(Attach copy of report) MONTH DAY YEAR

3. Treatment received for positive PPD/CXR: (describe): _____

B. POLIO:

1. Completed primary series of polio immunizations _____
MONTH DAY YEAR

C. MEASLES, MUMPS, RUBELLA:

ESU requires that all entering college students born after 1956 have 2 doses of the live measles vaccine in order to keep in compliance with the American College Health Association Guidelines. If you are unable to provide documentation of dates of immunization, a copy of blood titer results will be accepted. Consult your physician to have these laboratory tests completed.

MMR#1 _____
MONTH DAY YEAR

MMR#2 _____
MONTH DAY YEAR

OR Measles #1 _____
MONTH DAY YEAR

Measles #2 _____
MONTH DAY YEAR

Rubella _____
MONTH DAY YEAR

Mumps _____
MONTH DAY YEAR

OR Attach copy of blood titer(s) lab report showing positive immunity.

(PRINT) LAST NAME

FIRST NAME

MIDDLE

SOC. SEC. NO.

D. TETANUS-DIPHTHERIA-PERTUSIS

1. Completed primary series of tetanus-diphtheria immunizations _____
MONTH DAY YEAR

2. Received Td booster within the last 10 years _____
MONTH DAY YEAR

OR

3. Received Tdap within the last 10 years _____
MONTH DAY YEAR

E. MENINGITIS VACCINATION (Given within the past 1-3 years)

1. Meningitis vaccination

Menomune (Given within the past 1-3 years) _____ or Menactra _____
MONTH DAY YEAR MONTH DAY YEAR

2. Student has been advised of the risks associated with meningococcal disease, the availability/effectiveness of vaccination and has decided not to receive the vaccination.

STUDENT SIGNATURE

DATE

PARENT/LEGAL GUARDIAN SIGNATURE

DATE

(If student is a minor under 18 years old)

RECOMMENDED IMMUNIZATIONS

F. HEPATITIS:

1. Hepatitis B: Dose 1 _____ Dose 2 _____ Dose 3 _____
MONTH DAY YEAR MONTH DAY YEAR MONTH DAY YEAR

2. Hepatitis A: Dose 1 _____ Dose 2 _____
MONTH DAY YEAR MONTH DAY YEAR

3. Hepatitis A+B combined: Dose 1 _____ Dose 2 _____ Dose 3 _____
MONTH DAY YEAR MONTH DAY YEAR MONTH DAY YEAR

G. VARICELLA:

Dose 1 _____ Dose 2 _____
MONTH DAY YEAR MONTH DAY YEAR

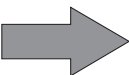
H. HUMAN PAPILLOMA VIRUS (HPV):

Dose 1 _____ Dose 2 _____ Dose 3 _____
MONTH DAY YEAR MONTH DAY YEAR MONTH DAY YEAR

REQUIRED PHYSICIAN'S VERIFICATION OF IMMUNIZATIONS

(or attach official documentation verifying immunizations dates)

REQUIRED



PHYSICIAN'S SIGNATURE, M.D. OR D.O.
(If completed by PAC or nurse practitioner include name of Physician Association)

DATE OF EXAM

(PRINT) PHYSICIAN'S NAME

TELEPHONE

ADDRESS

CITY OR TOWN

STATE

ZIP CODE

(PRINT) LAST NAME

FIRST NAME

MIDDLE

SOC. SEC. NO.

PHYSICIAN'S HEALTH EVALUATION

(Must be completed within the past year)

TO THE EXAMINING PHYSICIAN: Please review the student's Report of Medical History and complete this form, commenting on all positive answers. Information will be used as a background for providing appropriate health care. THE INFORMATION YOU PROVIDE IS SOLELY FOR THE USE OF THE UNIVERSITY HEALTH SERVICES AND WILL BE RELEASED UPON AUTHORIZATION/CONSENT OF THE STUDENT.

Blood Pressure: _____ / _____ Corrected Vision: Right 20/ _____ Color Vision: Normal Suggested Laboratory Studies: Hgb _____

Height: _____ ft. _____ in. Left 20/ _____ Abnormal Hct _____

Weight: _____ lbs. Chol _____

U/A _____

Other _____

ARE THERE ANY IRREGULARITIES OF THE FOLLOWING SYSTEMS?

	Yes	No		Yes	No
Cardiovascular			Musculoskeletal		
Dental			Neuro/Psychiatric		
Eyes			Respiratory		
Gastrointestinal			Skin		
Genitourinary			Is there absence or seriously impaired function of any organ?		
Ears, Nose, Throat			Have you any general comments?		
Immune			Is the student under treatment for eating disorder, emotional, or psychiatric problems?		
Metabolic/Endocrine					

RECOMMENDATION FOR PHYSICAL ACTIVITY: Limited Unlimited
 (If limited, please explain limitations below.)

COMMENTS: _____

IS THE STUDENT CURRENTLY TAKING ANY LONG-TERM MEDICATION? Yes No
 (If yes, please indicate the drugs and dosage below.)

REQUIRED 

 PHYSICIAN'S SIGNATURE, M.D. OR D.O. DATE OF EXAM
 (If completed by PAC or nurse practitioner include name of Physician Association)

 (PRINT) PHYSICIAN'S NAME TELEPHONE

 ADDRESS CITY OR TOWN STATE ZIP CODE

RETURN FORM TO:
 University Health Services, Flagler-Metzgar Center, East Stroudsburg University
 East Stroudsburg, PA 18301-2999
 (570) 422-3553 - Fax (570) 422-3731