In order to provide you with the best care possible, it is important to review significant health issues that might impact your health.

Our health screening form is given to students on their first visit to the health center. You may leave any questions blank if you choose. This form is a confidential document that will be kept in your medical record in the University Health Center. **No information may be released without your written consent, unless required by law.**

With few exceptions, you have the right to request, receive, review and correct information about yourself collected using this form (H. B. 1922, 77th Legislature).

### Section I

**Allergies**

(List all) reaction medication dosage (if known)

________________    _____________________

________________________    ________________________

________________    _____________________

________________________    ________________________

**Hospitalizations/surgeries**

year reason

________________________

**Serious illnesses or injuries**

year reason

________________________

**Immunizations**

1. Do you need immunizations? Yes No Unsure If yes, which ones?

2. Have you been immunized for hepatitis B? Yes No Unsure

3. Have you been immunized for meningitis? Yes No Unsure

4. When was your last tetanus shot? When was your last PPD (tuberculosis test)?

**Health Habits**

1. Have you ever used tobacco products regularly? Yes No If yes, which ones?

2. Do you currently smoke cigarettes? Yes No If yes, how often? __________

3. Do you exercise regularly? Yes No If yes, what type?

4. Do you have concerns about your appearance or weight? Yes No

**Family History**

Have any close relatives (parents, siblings) ever had any of the following (check all that apply)?

- Allergies
- Hereditary disease
- Depression/psychiatric illness
- Blood clotting disorders
- High blood pressure
- Diabetes
- Cancer
- High cholesterol
- Heart disease
- Stroke
- Tuberculosis
- Other serious illness

Explain any items checked

(Continued on Back)

### Section II

**Personal History**: Have you had or do you now have any of the following? If yes, note date of occurrence if known.

<table>
<thead>
<tr>
<th>Head / neurological</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent headaches/migraines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness or fainting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head injuries</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain (severe / recurrent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel movement problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood in stool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swollen or painful joints or extremities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic or severe back problems</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued on Back)

<table>
<thead>
<tr>
<th>Ears / Nose / Throat</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chronic diseases</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
### Patient History Form

#### Allergies or hay fever
- [ ] Yes
- [ ] No

#### Ear or hearing problems
- [ ] Yes
- [ ] No

#### Frequent sinusitis
- [ ] Yes
- [ ] No

#### Dental problems or TMJ
- [ ] Yes
- [ ] No

#### Skin
- Severe acne or skin disorder: [ ] Yes
- New or changing moles: [ ] Yes

#### Blood disorder
- Anemia: [ ] Yes
- Bleeding disorder: [ ] Yes
- Enlargement of glands or lymph nodes: [ ] Yes

#### Heart / circulation / chest
- Severe chest pain or pressure: [ ] Yes
- Heart disease or murmur: [ ] Yes
- Rapid or irregular pulse: [ ] Yes
- Blood clots or vein problems: [ ] Yes

#### Additional medical history
- Cancer: [ ] Yes
- Unusual fatigue (over 1 month): [ ] Yes
- Recent gain or loss of weight (over 10 pounds): [ ] Yes
- Eating disorder: [ ] Yes

#### For all students

By signing below I verify that the information provided on this form is correct.

**Date** ________________  **Student Signature**

#### Immunizations

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT/DTaP/DT/Td #1</td>
<td></td>
</tr>
<tr>
<td>DPT/DTaP/DT/Td #2</td>
<td></td>
</tr>
<tr>
<td>DPT/DTaP/DT/Td #3</td>
<td></td>
</tr>
<tr>
<td>DPT/DTaP/DT/Td Booster</td>
<td></td>
</tr>
<tr>
<td>DPT/DTaP/DT/Td Booster</td>
<td></td>
</tr>
<tr>
<td>(last tetanus within 10 years)</td>
<td></td>
</tr>
<tr>
<td>OPV/IPV</td>
<td></td>
</tr>
<tr>
<td>OPV/IPV</td>
<td></td>
</tr>
<tr>
<td>OPV/IPV</td>
<td></td>
</tr>
<tr>
<td>OPV/IPV</td>
<td></td>
</tr>
<tr>
<td>MMR #1</td>
<td></td>
</tr>
<tr>
<td>MMR #2</td>
<td></td>
</tr>
<tr>
<td>Measles-imm, titer, or disease</td>
<td></td>
</tr>
<tr>
<td>Mumps-imm, titer, or disease</td>
<td></td>
</tr>
<tr>
<td>Rubella-imm, titer, or disease</td>
<td></td>
</tr>
<tr>
<td>Hep B #1</td>
<td></td>
</tr>
<tr>
<td>Hep B #2</td>
<td></td>
</tr>
<tr>
<td>Hep B #3</td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
</tr>
</tbody>
</table>

#### Parental Consent and Medical Release

The following must be signed if the person covered by this history form is under 18 years of age.

I give my permission for the necessary medical treatment of this student by a physician and/or medical care facility as may be required. In the case of serious medical emergency, I understand that attempts will be made to contact me.

**Date** ________________  **Parent or Guardian Signature**

Reviewed by: ____________________________

Review date: ____________________________

**Reviewed by Date** ________________  **Signature of official certifying record**