

**REPORT OF MEDICAL HISTORY (Please type or print in black ink) TO BE COMPLETED BY STUDENT**

LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE NAME \_\_\_\_\_ \*SOCIAL SECURITY NO. \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ AREA CODE/PHONE \_\_\_\_\_

DATE OF BIRTH (MO/DAY/YR) \_\_\_\_\_ GENDER  M  F MARITAL STATUS  S  M  OTHER

PREVIOUSLY ENROLLED HERE  YES  NO  
 PREVIOUSLY A PATIENT HERE  YES  NO

SEMESTER ENTERING (CIRCLE): FALL  
 SPRING SUMMER OTHER YEAR \_\_\_\_\_

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) \_\_\_\_\_ TELEPHONE \_\_\_\_\_

NAME OF POLICY HOLDER \_\_\_\_\_ \*SOCIAL SECURITY NO. \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
 IS THIS AN HMO/PPO/MANAGED CARE PLAN?  YES  NO

POLICY OR CERTIFICATE NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ AREA CODE/PHONE \_\_\_\_\_

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

**FAMILY & PERSONAL HEALTH HISTORY (Please type or print in black ink)**

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
High blood pressure			
Stroke			
Cancer (type: _____)			
Heart attack before age 55			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Blood or clotting disorder			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
High blood pressure				Mononucleosis				Self-induced vomiting				Back injury			
Rheumatic fever				Hay fever				Frequent vomiting				Broken bones			
Heart trouble				Head or neck radiation treatments				Gall bladder trouble/gallstones				Kidney infection			
Pain or pressure in chest				Arthritis				Jaundice or hepatitis				Kidney stone			
Shortness of breath				Concussion				Rectal disease				Protein or blood in urine			
Asthma				Frequent or sever headache				Severe or recurrent abdominal pain				Hearing loss			
Pneumonia				Dizziness or fainting spells				Hernia				Sinusitis			
Chronic cough				Severe head injury				Easy fatigability				Severe menstrual cramps			
Tuberculosis				Paralysis				Anemia or Sickle Cell Anemia				Irregular periods			
Tumor or cancer (specify)				Epilepsy/seizures				Eye trouble besides need glasses				Blood transfusion			
Malaria				Disabling depression				Bone, joint or other deformity				Smoke 1 + pack cigarettes/week			
Thyroid trouble				Excessive worry or anxiety				Shoulder dislocation				Diabetes			
Serious skin disease				Ulcer (duodenal or stomach)				Knee problems				Anorexia/Bulimia			
Alcohol/drug use				Intestinal trouble				Recurrent back pain				Allergy injection therapy			
Sexually transmitted disease				Pilonidal cyst				Neck injury							

Please describe any conditions or disabilities that would exclude participation in physical education. \_\_\_\_\_

Do you exercise three or four times per week?  Yes  No Do you use a seat belt on a regular basis?  Yes  No

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_  
 Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

\* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide identifier for the internal records of this institution.

**FAMILY & PERSONAL HEALTH HISTORY - CONTINUED** (Please type or print in black ink)

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Have you ever been a patient in any type of hospital? (Specify when, where, and why.)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain.)			
Is there loss or seriously impaired function of any paired organs? (Please describe.)			
Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe.)			
Have you ever had any serious illness or injury other than those already noted? (Specify when and where and give details.)			

**IMPORTANT INFORMATION....PLEASE READ AND COMPLETE**

**STATEMENT BY STUDENT OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18:**

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student health Service to release information from my (son/daughter's) medical record to a physician, hospital, or other medical agency involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student health Service.

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian if under age 18

\_\_\_\_\_  
Date

## GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

### IMPORTANT

- **The Immunization Record form must be completed.**
- Records must be documented in black INK and all corrections must be signed.
- All dates must include **month, day and year** of administration.
- Your immunization records may be obtained from your high school, physician, health department, military record, or previously attended college. These records may not fulfill all requirements as listed below. It is your responsibility to assure compliance with required immunizations.
- Records must include a physician's signature, health department stamp, or high school record attachment.

### SECTION A... Immunizations that are REQUIRED pursuant to NC state law and institutional policy.

#### **Students 17 years of age or younger. . . . . REQUIRED:**

- 3 DTP (Diphtheria, Tetanus, Pertussis) or Td (Tetanus, Diphtheria) doses; one Td booster must have been within the past 10 years.
- 3 Polio (oral) doses
- 2 Measles (Rubeola), 1 Mumps, 1 Rubella (2 MMR doses meet this requirement)
- Tuberculin Skin Test (PPD) and result within the **twelve months preceding** the beginning of classes (chest x-ray report required if test is positive).

#### **Students born in 1957 or later and 18 years of age or older. . . . . REQUIRED:**

- 3 DTP (Diphtheria, Tetanus, Pertussis) or Td (Tetanus, Diphtheria) doses; one Td booster must have been within the past 10 years.
- 2 Measles (Rubeola), 1 Mumps, 1 Rubella (2 MMR doses meet this requirement)
- Tuberculin Skin Test (PPD) and result within the **twelve months preceding** the beginning of classes (chest x-ray report required if test is positive).

#### **Students born before 1957 . . . . . REQUIRED:**

- 3 DTP (Diphtheria, Tetanus, Pertussis) or Td (Tetanus, Diphtheria) doses; one Td booster must have been within the past 10 years.
- 1 Rubella (MMR meets this requirement) (not required if student is 50 years of age or older).
- Tuberculin Skin Test (PPD) and result within the **twelve months preceding** the beginning of classes (chest x-ray report required if test is positive).

### NOTE...

- History of Measles (Rubeola) is acceptable if physician verifies that student had the disease prior to January 1, 1994.
- Blood titer tests are acceptable for Measles, Mumps, Rubella and Hepatitis B. Laboratory test results must be attached.
- Students who entered college after 7/1/94 must have **two doses** of Measles (Rubeola) vaccine after the first birthday (2 MMR meet this requirement).

### SECTION B... Recommended vaccines that **MAY BE REQUIRED** by certain universities or departments (for example, health sciences). Please consult your university or department materials for specific requirements.

### SECTION C... These vaccines are **OPTIONAL** or for future use.

**IMMUNIZATION RECORD** (Please type or print in black ink) **TO BE COMPLETED & SIGNED BY PHYSICIAN OR CLINIC**

LAST NAME	FIRST NAME MIDDLE NAME	DATE OF BIRTH (mo/day/year)
		SOCIAL SECURITY NUMBER

**SECTION A... Required Immunizations**

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
• DPT or Td	#1	#2	#3	#4
• Td Booster				
• Polio				
• MMR (after first birthday)				
• MR (after first birthday)				
• Measles (after first birthday)			Disease Date	**Titer Date & Result
• Mumps			(Disease Date NOT Accepted)	**Titer Date & Result
• Rubella			(Disease Date NOT Accepted)	**Titer Date & Result
• Tuberculin (PPD) Test	Date Read			
(within 12 months)	mm induration			
.....	Date			
Chest x-ray, if positive PPD	Results			
.....	Date			
Treatment, if applicable				

**SECTION B...** The following immunizations are recommended for all students and may be required by certain universities or departments (for example, health sciences). Please consult your university or department materials for specific requirements.

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
• Hepatitis B series				**Titer Date & Result
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	**Titer Date & Result

\*\*attach lab report

**SECTION C... Optional Vaccines**

	mo/day/year	mo/day/year	mo/day/year
• Hemophilus Influenzae, b			
• Pneumococcal			
• Meningococcal			
• Hepatitis A Series			
• Typhoid			
• Other			

**Signature or Clinic Stamp REQUIRED:**

\_\_\_\_\_  
Signature of Physician/Physician Assistant/Nurse Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Physician/Physician Assistant/Nurse Practitioner

\_\_\_\_\_  
Area Code/Phone Number

\_\_\_\_\_  
Office Address

\* You may request a copy of your medical records while at Chowan University free of charge. But after leaving the University the cost will be \$5.00. Records of former students are available for up to three years after leaving the university.

**Do Not Write In This Space**

# PHYSICAL EXAMINATION

(Please type or print in black ink)

(A physical examination is required by some universities, colleges or departments. Please consult instructions on front sheet or your university or department materials for specific requirements.)

Last Name	First Name	Middle Name
Date of Birth (mo/day/year)		*Social Security Number

Permanent Address	City	State
ZIP Code		Area Code/Phone Number

Height \_\_\_\_\_ Weight \_\_\_\_\_ TPR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

<b>Vision:</b> Corrected Right 20/____ Left 20/____ Uncorrected Right 20/____ Left 20/____ Color Vision _____ <b>Hearing:</b> (gross) Right _____ Left _____ 15 ft. Right _____ Left _____	<b>Urinalysis:</b> Sugar _____ Albumin _____ Micro _____ Hgb or Hct (if indicated) _____ STS (may be required by some departments) Date _____ Results _____ Recommendations _____
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Are there abnormalities? If so, describe fully	YES	NO	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

- A. Is there loss or seriously impaired function of any paired organs? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_
- B. Is student under treatment for any medical or emotional condition? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_
- C. Recommendations for physical activity (physical education, intramurals, etc.) Unlimited \_\_\_\_\_ Limited \_\_\_\_\_  
 Explain \_\_\_\_\_
- D. Is student physically and emotionally healthy? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_

*Only For Students Admitted to a <b>HEALTH PROFESSIONAL PROGRAM</b> (for example, Nursing)*
Based on my assessment of this student's physical and emotional health on _____ <sup>(date)</sup> , he/she appears able to participate in the activities of a health professional in a clinical setting. Yes ___ No ___ If no, please explain: _____

Signature of Physician/Physician Assistant/Nurse Practitioner \_\_\_\_\_ Date \_\_\_\_\_

Print Name of Physician/Physician Assistant/Nurse Practitioner \_\_\_\_\_

Office Address \_\_\_\_\_ Area Code Phone Number \_\_\_\_\_

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