MAIL TO: Chowan University Wellness Center • One University Place, Murfreesboro, NC 27855

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_____

HEALTH INSURANCE (NAME & ADDRESS OF COMPANY) ****PLEASE ATTACH COPY OF CARD**** 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
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Tuberculosis			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Serious skin disease			
Alcohol/drug use			
Sexually transmitted disease			

	Yes	No	Year
Mononucleosis			
Hay fever			
Head or neck radiation treatments			
Arthritis			
Concussion			
Frequent or sever headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Epilepsy/seizures			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			

	Yes	No	Year
Self-induced vomiting			
Frequent vomiting			
Gall bladder trouble/gallstones			
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint or other deformity			
Shoulder dislocation			
Knee problems			
Recurrent back pain			
Neck injury			

	Yes	No	Year
Back injury			
Broken bones			
Kidney infection			
Kidney stone			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Blood transfusion			
Smoke 1 + pack cigarettes/week			
Diabetes			
Anorexia/Bulimia			
Allergy injection therapy			

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 hospital or psychiatric ER? (When, where, why)			
Have you ever been depressed for weeks, lost interest in activities, trouble concentrating, or thought about killing yourself?			
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... THESE VACCINES ARE REQUIRED

- 3 Hepatitis B doses
- 2 Varicella (chicken pox) doses

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/ CLINIC

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

SECTION A... Required Immunizations

	#1 mo/day/year	#2 mo/day/year	#3 mo/day/year	#4 mo/day/year
• DTP or Td				
• Td Booster/Tdap (within the past 10 years)				
• 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 Placed** _____ **Date Read**				
(within 12 months) **mm**				
Chest x-ray, if positive PPD Date				
Results				
Treatment, if applicable Date				

seCTION B... Required Immunizations

	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			
• COVID-19			

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 _____/_____

Vision: Corrected Right 20/____ Left 20/____

Uncorrected Right 20/____ Left 20/____

Color Vision _____

Hearing: (gross) Right _____ Left _____

15 ft. Right _____ Left _____

Urinalysis: Sugar _____ Albumin _____

Micro _____

Hgb or Hct (if indicated) _____

STS (may be required by some departments)

Date _____ Results _____

Recommendations _____

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 HEALTH PROFESSIONAL PROGRAM (for example, Nursing)•

Based on my assessment of this student's physical and emotional health on _____ (date), 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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