Health History Form
(Required)

Student Health Center
West Chester University
West Chester, PA 19383

Health History form must be submitted prior to registration for any program of study.

Please return this form in the envelope provided to:
West Chester Student Health Center
West Chester University
West Chester, PA 19383

For more information, please call
(610) 436-2509

COMPLETION INSTRUCTIONS:

Complete Part One (if under 18 years of age) through Part Six.

Use a PENCIL ONLY.

Make solid marks that fill the oval completely.
Erase cleanly any mistakes or marks you wish to change.
Make no stray marks on this form.
Do not fold, tear, or mutilate this form.

To ensure quality of care, please complete text boxes as well as ovals. This form will be reviewed by a provider each time you visit the health center.

Correct Mark ► ⬬

CONFIDENTIALITY:

This information is strictly for the use of West Chester University Student Health Center. We do not release information without your written permission, except upon court order, as required by law (as in the case of certain communicable diseases and reports of child abuse), or as required, in our judgement, to protect you or others from immediate physical danger.

Please attach a copy of student health insurance card.

PART ONE — PERMISSION TO TREAT

➡ *TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN*
(For treatment of minors under 18 years of age)

I give my permission for my daughter/son/ward ______________________
to receive primary care, or urgent care by the staff at West Chester University Student Health Center, in the event of an injury or illness. I understand that I will be responsible for all charges for health services provided by West Chester University Student Health Center and by off-campus providers.

Signature ______________________ Date ________

Relationship ______________________

PART TWO — GENERAL INFORMATION

➡ *TO BE COMPLETED BY STUDENT/PARENT/GUARDIAN*

2A PARENT/GUARDIAN SECTION

PARENT 1
Name:
Work Phone: (   )
Age: Occupation:

PARENT 2
Name:
Work Phone: (   )
Age: Occupation:

2B PERSON TO NOTIFY IN CASE OF EMERGENCY (If other than above)

Name:
Home Phone: (   )
Work Phone: (   )
Relationship:

2C IDENTIFICATION/STUDENT

Name:
Signature:

Home Address:
Street
City State ZIP or Postal Code Country
Home Phone: (   )
Cell Phone: (   )
Email Address:

Gender ◯ Female ◯ Male

Are you a U.S. citizen (naturalized or born in the U.S.)?
◯ Yes ◯ No

◯ **Registered Student**
◯ Undergraduate
◯ Graduate

Birth Date

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

Student ID

0					
●	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

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PLEASE DO NOT WRITE IN THIS AREA

Last Name

First Name

MI

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

PART THREE — MEDICAL HISTORY

TO BE COMPLETED BY STUDENT/PARENT/GUARDIAN

3A FAMILY MEDICAL HISTORY

If any of your blood relatives (parents, grandparents, siblings, children, etc.) has had any of the following diseases, mark the appropriate responses.

- Alcohol/drug problem
- Asthma or hay fever
- Cancer
- Diabetes
- Heart disease
- Hereditary disorder
- High blood pressure
- Migraine

Are you adopted? Yes No

In parts 3B through 3D, mark any of the following that are, or have been, significant concerns and explain in the space provided.

3B PERSONAL MEDICAL HISTORY

- Alcohol problem or substance abuse
- Asthma
- Cancer
- Chicken Pox
- Diabetes mellitus
- Eating disorders
- Eye disease
- Head injury with unconsciousness
- Hearing impairment
- Heart disease
- Hepatitis B disease **Carrier?** Yes No
- Hepatitis C disease
- High blood pressure
- HIV positive
- Kidney disease
- Locomotion impairment
- Malaria
- Migraine
- Neurologic disorder
- Psychological or emotional concerns
- Seizures
- Sexually transmitted disease
- Smoking/tobacco
- Vision deficit
- Major surgery *(specify)*

Please provide a brief explanation of all items you marked above:

U.S. citizens, please indicate if you have lived outside the country.

COUNTRY — FROM (MM/DD/YY) — TO (MM/DD/YY)

Name:

3C ALLERGIES: DRUGS AND OTHER SEVERE ADVERSE REACTIONS

- ◯ Acetaminophen
- ◯ Aspirin
- ◯ Food
- ◯ Insect/bee sting
- ◯ Latex
- ◯ Lidocaine/Xylocaine
- ◯ Penicillin
- ◯ Sulfa
- ◯ Xray contrast
- ◯ Other *(specify)*
- ◯ No known allergies

Please provide a brief explanation of all allergies you indicated to the left:

3D MEDICATIONS (Frequent or Regular)

- ◯ Acne medication
- ◯ Allergy medicines
- ◯ Allergy shots
- ◯ Antidepressants
- ◯ Asthma medication
- ◯ Birth-control pills
- ◯ Bowel medication
- ◯ Seizure medication
- ◯ Headache medication
- ◯ Heart-rhythm medication
- ◯ Insulin
- ◯ Pain medication
- ◯ Thyroid medication
- ◯ Tranquilizers
- ◯ Other *(specify)*

Please provide the name, dosage and indication for the medications you marked above.

PART FOUR IMMUNIZATIONS

*TO BE COMPLETED BY MEDICAL PROVIDER **OR** STUDENT/PARENT/GUARDIAN UNDER GUIDANCE OF A MEDICAL PROVIDER*

4A REQUIRED IMMUNIZATIONS *Completion mandatory*

All questions in this section must be completed. Please INDICATE BY MONTH, DAY, AND YEAR THE DATES of vaccinations, diagnoses, or laboratory tests. (Note: Students born before 1957 are exempt from the measles, mumps, rubella requirement.)

TDAP

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

Tetanus: original series plus a booster within ten years.

Date of Last Booster

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

▶ Measles/Mumps/Rubella: two doses of live MMR administered on or after the first birthday:

Dose 1

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

Dose 2

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

OR if vaccines were given separately:

▶ Measles: two doses of live vaccine administered on or after the first birthday:

Dose 1

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

Dose 2

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

▶ **OR physician-diagnosed history of disease:** *Complete date field to the right.*

▶ **OR protective-antibody titer:**
Lab: ◯ Positive ◯ Negative
If positive then complete date field. If negative go on.

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

▶ Mumps:

◯ one dose of live vaccine administered on or after the first birthday: *Complete date field to the right.*

▶ **OR** ◯ physician-diagnosed history of disease: *Complete date field to the right.*

▶ **OR protective-antibody titer:**
Lab: ◯ Positive ◯ Negative
If positive then complete date field. If negative go on.

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

▶ Rubella: one dose of live vaccine administered on or after the first birthday:

(Note: Previous clinical diagnosis of rubella is not sufficient) Complete date field to the right.

▶ **OR protective-antibody titer:**
Lab: ◯ Positive ◯ Negative
If positive then complete date field. If negative go on.

Month	DAY		YEAR			
◯ Jan						
◯ Feb						
◯ Mar	0	0		0	0	0
◯ Apr	1	1	1	1	1	1
◯ May	2	2	2	2	2	2
◯ June	3	3		3	3	3
◯ July		4		4	4	4
◯ Aug		5		5	5	5
◯ Sept		6		6	6	6
◯ Oct		7		7	7	7
◯ Nov		8		8	8	8
◯ Dec		9		9	9	9

PLEASE DO NOT WRITE IN THIS AREA

4B TUBERCULIN SCREENING

Completion recommended for all students.

Please indicate by month, day, and year the dates of vaccinations, laboratory tests, or treatment.

Note: The Tuberculin recommendation applies regardless of BCG vaccination.

Tuberculin Test (PPD, Mantoux):

within one year prior to matriculation to West Chester University:

Result: ▶ mm of induration

0	0
1	1
2	2
3	3
	4
	5
	6
	7
	8
	9

Result: ▼

◯ Positive ◯ Negative

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Chest X-ray within one year of entry if history of positive tuberculin test.

Result: ▼

◯ Positive ◯ Negative

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

History of treatment for

◯ Tuberculosis ◯ PPD conversion

Treatment completed as directed?

◯ Yes ◯ No

Start date, duration and type of treatment:

4C RECOMMENDED IMMUNIZATIONS

The American College Health Association (ACHA) and the Center for Disease Control (CDC) recommends that all students consider receiving the following immunizations:

Chicken Pox (varicella)

Date of Completion:

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Meningococcal

Mandatory for all students residing in University Housing.

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Hepatitis B Vaccine Series

Dose 1

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Dose 2

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Dose 3

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

4D OTHER VACCINATIONS YOU MAY HAVE RECEIVED

BCG Vaccine (tuberculosis)

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

HIB Vaccine

(Haemophilus Influenzae B)

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Pneumococcal Vaccine

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Polio Vaccine

(before age 18) Date of Completion:

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Vaccine used:

Rabies Vaccine

Date of Completion:

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Hepatitis A Vaccine

Date of Completion:

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

HPV

Dose 1

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Dose 2

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Dose 3

Month	DAY		YEAR			
Jan						
Feb						
Mar	0	0		0	0	0
Apr	1	1	1	1	1	1
May	2	2	2	2	2	2
June	3	3		3	3	3
July		4		4	4	4
Aug		5		5	5	5
Sept		6		6	6	6
Oct		7		7	7	7
Nov		8		8	8	8
Dec		9		9	9	9

Name:

PART FIVE — PHYSICAL EXAMINATION

TO BE COMPLETED BY MEDICAL PROVIDER

Date of physical exam:

5A GENERAL MEDICAL INFORMATION

Height (FT / INCHES)	Weight (POUNDS)	Blood Pressure (SYS / DIAS)	Pulse	Visual Acuity: Left Eye CORRECTED 20:	Left Eye UNCORRECTED 20:	Right Eye CORRECTED 20:	Right Eye UNCORRECTED 20:
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

Mark response if normal.

- Eyes/pupils
- Mouth/teeth
- Neck/thyroid
- Lungs
- Heart
- Abdomen/hernia
- Testicles
- Pelvic exam
- Skin

Comment on abnormals:

5B ORTHOPEDICS

(Including ranges of motion, surgical scars, and anomalies)

Mark response if normal.

- Neck
- Back
- Shoulders
- Elbows
- Hands
- Hips
- Knees
- Ankles
- Feet

Comment on abnormals:

5C CLINICAL TESTS

Completion optional

Urinalysis

Other test results:

Hemoglobin (g/dl)		Hematocrit (%)
0 1 2 3 4 5 6 7 8 9	OR	0 1 2 3 4 5 6 7 8 9

5D ORGAN LOSS

Does this student have evidence of a loss of any paired organ?

Yes   No   If Yes: *(Specify)*

5E RECOMMENDATIONS FOR PHYSICAL ACTIVITY

Is this student medically able to participate in contact sports?   Yes   No

If no, please specify recommendations for physical activity:

Men's contact sports: basketball, football, hockey, lacrosse, soccer
Men's Sports Club: rugby, martial arts
Women's contact sports: basketball, field hockey, lacrosse, soccer
Women's Sports Club: rugby, martial arts

5F ONGOING MEDICAL CARE

Is the student under care for a chronic condition or serious illness?   Yes *(specify condition below)*   No

▶ *If Yes, include clinical reports with form.*

Other recommendations for continuing care:

PART SIX — MEDICAL PROVIDER'S SIGNATURE

TO BE COMPLETED BY MEDICAL PROVIDER   *Completion mandatory (Signature required in ink)*

Medical Provider's Name:

Work Phone:

I agree with Part Four.   Yes   No

Medical Provider's Signature: X

Date:

I have completed Part Five.   Yes   No

Address:

Street

City   State or Province   ZIP or Postal Code   Country

PLEASE DO NOT WRITE OR STAMP IN THIS AREA

40901