HAMPTON UNIVERSITY HEALTH CENTER

Hampton, VA 23668

Confidential Medical History

DEADLINE MAY 1 (FALL SEMESTER) AND DECEMBER 1 (SPRING SEMESTER) OF THE CURRENT ENROLLMENT YEAR

Last Name: First Name: Middle Initial:

HU ID No.: Check Box: ☐ College of Continuing Studies ☐ Graduate

Permanent Home Address: Street: City: State: Zip:

Phone: Email Address:

Year Entering HU: DOB (mm/dd/yy): Sex ☐ M ☐ F Height: Weight:

Person to Notify in Case of Emergency: Relationship: Phone:

Y	N	MEDICATIONS....		
		Do you take any medications on a regular basis? If so, which medications:		
		Are you allergic to any medication? If so, which medication:	What was your reaction:	
Y	**N**	**HAVE YOU EVER....**	When?	Comments
		Spent the night in the hospital?		
		Had any surgery?		
		Had any serious illnessess or injuries?		
		Been assaulted *(physically, sexually)*?		
		Had psychological/psychiatric treatment?		
Y	N	**HAVE YOU EVER HAD PROBLEMS WITH YOUR....**		
		Head: Injury, loss of consciousness, skull fracture?		
		Eyes: Vision *(wear glasses or contacts)*? Injury?		
		Ears, Nose, Throat, Jaw: Infections? Decreased hearing? Environmental allergies? Tonsillectomy? "Mono"? TMJ?		
		Lungs: Asthma? TB Exposure? Pneumonia? Wheezing or Cough?		
		Heart: High blood pressure? Murmur? High cholesterol? Arrhythmia *(diagnosed abnormal heart rhythm)*? Chest Pain? Palpitations? Heart Failure?		
		Eating Habits: Currently dieting? Eating disorder?		
		Digestive: Ulcer? Hepatitis? Colitis?		
		Reproductive: Infectious *(chlamydia, gonorrhea, warts, herpes)*? Breast lump? Endometriosis, ovarian cyst, pregnancy, abnormal pap?		
		Urinary: Kidney stone? UTI *(kidney or bladder infection)*? Kidney disease?		
		Musculoskeletal: Injury? Fracture? Arthritis? Scoliosis? Severe Sprains?		
		Neurologic: Seizure? Headaches, migraine?		
		Skin: Acne? Eczema?		
		Endocrine: Diabetes? Thyroid problems? Dehydration?		
		Blood: Anemia? Sickle cell trait? Clots?		
		Other: Depression, anxiety, drug or alcohol problems?		
Y	N	**HABITS....**		
		Do you use tobacco? If cigarettes, how many per day?	If other, what:	How much:
		Do you drink alcohol? If yes, number drinks at a time on average: Number of times per *(circle)* week, month, year:		
		Do you use any drugs?	If yes, what:	
Y	N	**FAMILY HISTORY....**		
		Are you adopted? *(If so, please omit the following sections unless you know your biological family's medical history.)*		
		Have any of your biological parents or siblings died? If yes, please state who has died, with their ages and cause of death:		
		Relationship:	Age of death:	Cause of death:
		Relationship:	Age of death:	Cause of death:
Y	N	Have any biological family members *(grandparents, parents, siblings)* been diagnosed with the following conditions?		
		Cancer? If yes, who: What type:	Age of onset:	Comments:
		High blood pressure? If yes, who:	Age of onset:	Comments:
		Diabetes? If yes, who:	Age of onset:	Comments:
		Heart disease? High cholesterol? Heart failure? If yes, who:	Age of onset:	Comments:
		Stroke? Blood clot? If yes, who:	Age of onset:	Comments:
		Psychiatric problems, alcohol abuse, drug abuse? If yes, who:	Age of onset:	Comments:

SIGNATURE REQUIRED: ***To the best of my knowledge, this information is accurate.***

Signed:

IMMUNIZATION RECORD

**Immunity is required prior to registration. Please complete and return this form.*

NAME ______________________ LAST ______________________ FIRST ____ M. I.

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER (Dates must include month and year.)

***A. TETANUS-DIPTHERIA**

1. ☐ Completed primary series of tetanus-diptheria immunizations.......... MONTH DATE YEAR
2. ☐ Received tetanus-diptheria booster (required every 10 years) .... MONTH DATE YEAR
3. ☐ Tdap (preferred) to replace single dose of Td for booster immunization with at least five years since last dose of Td.......... MONTH DATE YEAR

***B. M.M.R. (Measles, Mumps, Rubella)**

1. ☐ Dose 1 – Immunized at 12 months or after and before 5 years .... MONTH DATE YEAR
2. ☐ Dose 2 – Immunized at 5 years or later .... MONTH DATE YEAR

***C. MEASLES (Rubeola) – if given instead of MMR. Check appropriate box.**

1. ☐ Had disease; confirmed by office record.......... MONTH DATE YEAR
2. ☐ Born before 1957 and therefore considered immune.......... MONTH DATE YEAR
3. ☐ Has report of immune titer. Specify date of positive titer. .... MONTH DATE YEAR
4. ☐ Immunized with live measles vaccine at 12 months after birth or later.......... MONTH DATE YEAR

***D. RUBELLA – if given instead of MMR. Check appropriate box.**

1. ☐ Has report of immune titer. Specify date of positive titer .... MONTH DATE YEAR
2. ☐ Immunized with vaccine at 12 months after birth or later.......... MONTH DATE YEAR

***E. MUMPS – if given instead of MMR. Check appropriate box.**

1. ☐ Had disease; confirmed by office record.......... MONTH DATE YEAR
2. ☐ Has report of immune titer. Specify date of positive titer. .... MONTH DATE YEAR
3. ☐ Immunized with vaccine at 12 months after birth or later.......... MONTH DATE YEAR

F. TUBERCULOSIS – Interpretation based on mm of induration. *Check appropriate box.*

***(Required of International Students Only)**

1. ☐ PPD (Mantoux) test within the past year (Tine or monovac not acceptable) — Result: ☐ Positive ☐ Negative
   Give date placed.......... Date MONTH DATE YEAR
   Give date read and results (based on millimeters).......... Date MONTH DATE YEAR ______ mm
2. ☐ Positive PPD – Chest x-ray required. — Result: ☐ Positive ☐ Negative
   Give date and result of chest x-ray .... Date MONTH DATE YEAR
3. ☐ Had BCG vaccine – Chest x-ray required if PPD not done ...... Date MONTH DATE YEAR

***G. POLIO**

1. ☐ Completed primary series of polio immunization.......... ☐ Yes ☐ No MONTH DATE YEAR
   Type of vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV
   Last booster.......... MONTH DATE YEAR

***H. MENINGOCOCCAL MENINGITIS**

1. ☐ MENOMUNE - (Required every 3-5 years).......... MONTH DATE YEAR
2. ☐ Menactra - (Conjugate).......... MONTH DATE YEAR

I. ☐ HEPATITIS B VACCINE SERIES *(REQUIRED OR WAIVER)*.......... MONTH DATE YEAR
MONTH DATE YEAR
MONTH DATE YEAR

HEALTH CARE PROVIDER

Name ______________________ Address ______________________

Signature ______________________ Phone (____) ______________________

HC (6/11)