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 *(Required)

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) *(Required)

1. ☐ Dose 1 – Immunization date required at exactly 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 and send copy of positive results.** ..... 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 and send copy of positive results.** ..... 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 and send copy of positive results.** ..... 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)
   Give date placed ..... Date MONTH DATE YEAR — Result: ☐ Positive ☐ Negative
   Give date read and results (based on millimeters) ..... Date MONTH DATE YEAR _____ mm
2. ☐ Positive PPD – Chest x-ray required.
   Give date and result of chest x-ray ..... Date MONTH DATE YEAR — Result: ☐ Positive ☐ Negative
3. ☐ Had BCG vaccine – Chest x-ray required if PPD not done ..... Date MONTH DATE YEAR

G. POLIO *(Required)

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 *(Required)

1. ☐ MENOMUNE - **Immunization and updates as per CDC guidelines.** ..... MONTH DATE YEAR
2. ☐ Menactra - (Conjugate) **Immunization and updates as per CDC guidelines.** ..... MONTH DATE YEAR

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

***(Required for Health Care Profession Students)**

MONTH DATE YEAR

HEALTH CARE PROVIDER

Name _____ Address _____

Signature _____ Phone (____) _____

HC (Revised 05/13)