UAB STUDENT HEALTH SERVICES
Non-Clinical Student Health History Form
930 20th Street South, Suite 221
Birmingham, Alabama 35294-2042

Office Use Only:
Duplicate _____
____ Stars ____ Hold
____ Call Clearance ____ P

Entering Semester (*Circle One*): Spring Summer Fall ● Year _____ ● UAB Student No. _____

I. General Information

(Please print or type legibly in black ink) Have you ever filled out this form before? □Yes □No if yes, approximate year : _____

Full Name: _____ Social Security No. _____
(Print) Last/Family First MI.

Date of Birth: *Month*:_____ *Day*:_____ *Year*:_____ Sex:___ M ___ F

School: _____ **Program or Major Code:** _____
Public Health; SHP-Non-Clinical; International Student {Example: Health Administration; Health Education}

Do you have a Blazer ID? □Yes □No if yes, what is it?_____

Are you an International Student or Scholar? □Yes □No if yes, what country? _____

Current email address: (print clearly) _____

Telephone information: _____ _____ _____
Home *Cell* *Other*

Local address: _____

Permanent address: _____

Primary emergency contact: _____ Phone: _____ Relationship: _____

Secondary emergency contact: _____ Phone: _____ Relationship: _____

II. Medical History

1. Do you have any medical problems? (Such as asthma, diabetes, high blood pressure, etc.) □Yes □No if yes, please explain_____

2. Have you consulted a physician or been hospitalized within the past five years? □Yes □No if yes, please explain:

3. Please list any surgery, acute or chronic illnesses, and significant injuries which you have had including dates: _____

4. What is your present weight? _____ Your present height? _____ Have you had significant weight loss or gain recently? □Yes □No if yes, please explain: _____

5. Do you eat a balanced diet daily? □Yes □ No if no, would you like to have someone contact you regarding this? □Yes □ No
6. Do you smoke? □Yes □No if so, how much, and for how many years? If yes, do you wish to quit? □Yes □No
7. Do you drink alcoholic beverages? □Yes □No if so, type and number of drinks per week: _____
8. Are you concerned about your utilization of alcohol or drugs? □Yes □No
9. Do you have any restrictions on your physical activities? □Yes □No if yes, explain: _____
10. **Would you like for someone from the Counseling Center to contact me about mental health resources on campus? □Yes □No**
13. Is there any other information which would be helpful to the UAB Student Health Clinic in providing you with medical care?

III. Allergies and Current Medication

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 (hypersensitivity, 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)			

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_____

Name_____ Use_____ dosage_____, Name_____ Use_____ dosage_____

IV. Family & Personal Health History (To be completed by the student) Has any person, related by blood, had any of the following?

	Yes	No	Relationship
High Blood pressure			
Stroke			
Cancer			
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			
Suicide			

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/pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Tuberculosis			
Tumor/cancer (specify)			
Malaria			
Thyroid trouble			
Serious skin disease			
Alcohol/drug problem			
Sexually transmitted disease			
Sleep problems			

	Yes	No	Year
Mononucleosis			
Hay fever			
Head/neck radiation treat.			
Arthritis			
Concussion			
Frequent/severe headache			
Dizziness/fainting spells			
Severe head injury			
Paralysis			
Epilepsy/Seizures			
Depression/bipolar			
Anxiety/panic			
Ulcer (duodenal/stomach)			
Intestinal trouble			
Pilonidal cyst			
LD/ADD/ADHD			

	Yes	No	Year
Self-induced vomiting			
Frequent vomiting			
Gall bladder or gallstones			
Jaundice or Hepatitis			
Rectal disease			
Sev./recurrent abdmn. pain			
Hernia			
Chicken pox			
Anemia/Sickle Cell Anemia			
Eye trouble besides glasses			
Bone, joint, other deformity			
Shoulder dislocation			
Knee problems			
Recurrent back p			
Neck injury			
Self-injurious behavior			

	Yes	No	Year
Back injury			
Broken bones			
Kidney infection			
Bladder infection			
Kidney stone			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Blood transfusion			
Smoke 1+ packs cig/week			
Diabetes			
Eating Disorder			
Allergy injection therapy			
Obsessive/compulsive			

Immunization Record

Non-Clinical Domestic UAB Students

University of Alabama Birmingham

Submit immunization documentation to your CertifiedBackground.com account

Part I

Name_____
First Name Middle Name Last Name

Address_____
Street City State Zip

Today's Date___/___/___ Date of Birth___/___/___ Student ID#_____
Starts with a B

***This form is recommended, but not required. You may also submit copies of your actual immunization records in lieu of this form.**

Part II-TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER(S)—EACH ENTRY MUST BE INITIALED. *ALL INFORMATION/RECORDS MUST BE IN ENGLISH*

I. MEASLES/MUMPS/RUBELLA (MMR)*: ***TWO*** doses are required and must be at least 28 days apart after 12 months of age. ***** If you were born prior to January 1, 1957, you are exempt from this requirement.***

#1___/___/___ ***AND*** #2___/___/___ HCP Initials_____

****IF NOT GIVEN AN MMR COMBINATION OR HAD TITERS DRAWN, PLEASE COMPLETE THE FOLLOWING AND ATTACH A COPY OF ALL TITER LAB RESULTS:***

MEASLES (RUBEOLA): ***TWO*** doses OR a positive (level indicating immunity) IgG antibody titer. The vaccination doses must be at least 28 days apart after 12 months of age.

#1___/___/___ ***AND*** #2___/___/___ ***OR*** Positive titer___/___/___ HCP Initials_____

MUMPS: ***TWO*** doses OR a positive (level indicating immunity) IgG antibody titer. The vaccination doses must be at least 28 days apart after 12 months of age.

#1___/___/___ ***AND*** #2___/___/___ ***OR*** Positive titer___/___/___ HCP Initials_____

RUBELLA (GERMAN MEASLES): ***TWO*** doses OR a positive (level indicating immunity) IgG antibody titer. The vaccination doses must be at least 28 days apart after 12 months of age.

#1___/___/___ ***AND*** #2___/___/___ ***OR*** Positive titer___/___/___ HCP Initials_____

IF ANY OF THE IGG TITERS WERE LOW AND DID NOT INDICATE IMMUNITY AN MMR BOOSTER IS REQUIRED. Date of MMR booster___/___/___ HCP Initials_____

II. Tdap (TETANUS, DIPTHERIA & PERTUSSIS): One dose within the last 10 years. Tetanus and Tetanus/Diptheria boosters are not acceptable.

Date___/___/___ HCP Initials_____

IV. VARICELLA VACCINATION *is required for all without evidence of immunity.* ***** If you were born prior to January 1, 1980, you are exempt from this requirement.***

- ***Evidence of immunity is defined as:***
  - Written documentation of ***TWO*** doses of Varicella Vaccine and must be at least 28 days apart
  - A history of varicella disease or herpes zoster (shingles) based on a healthcare provider diagnosis, requiring provider documentation. Documentation from health department is not acceptable.
  - Laboratory evidence of immunity (a reactive VZVIgG antibody titer)

****For those students with a documented history of only one prior dose of varicella vaccine, one additional dose is required at least 4 weeks after that initial dose.**

#1___/___/___ ***AND*** #2___/___/___ HCP Initials_____

OR Verification of Varicella disease by healthcare provider: Date of disease ___/___/___ HCP Initials_____

OR Reactive VZVIgG titer ___/___/___ (***Attach a copy of lab result)*** HCP Initials_____

V. MENINGOCOCCAL: *Students up to and including age 21 must provide proof of immunization against meningococcal meningitis (Menactra, Menveo, or Menomune) since turning 16 years of age even if a vaccine dose was given at an earlier age.* Date___/___/___ HCP Initials_____

VI. TUBERCULOSIS: *Either a TB skin test done within 6 months of matriculation* ***OR*** *Interferon Gamma Release Assay (Quanteferon TB Gold or T-Spot) within 6 months of matriculation is required.*
*****Note: ALL TB testing, including blood tests, MUST be done in the United States.*****

Placement Date ___/___/___ **Read Date** ___/___/___ **Results**_____**mm** HCP Initials_____

OR

Quanteferon TB Gold or T-Spot (please circle) **Date** ___/___/___ **Results**_____ HCP Initials_____

Individuals with a history of a reactive Tuberculin skin test or blood test must provide a current chest x-ray (taken since their last positive TB test but within three months prior to enrolling or visiting), indicating the person is free of active tuberculosis as well as a UAB TB questionnaire.
*****NOTE: Chest X-rays must be done in the United States*****

CHEST X-RAY DATE ___/___/___ **CHEST X-RAY RESULT** _____ (***Attach a copy of x-ray report)*** HCP Initials_____

Treatment taken □ INH or □ Rifampin (check one)

Duration of therapy ___/___/___ to ___/___/___ (attach documentation) HCP Initials_____

Health Care Provider Signature _____ HCP Initials_____
HCP Printed Name _____ Date _____
Address _____
Phone Number _____
OR CLINIC STAMP