WALSH UNIVERSITY

MEDICAL HISTORY FORM

Voluntary form notice in regard to 84.42 Sect. 504

IMPORTANT: ALL RESIDENCE HALL STUDENTS must have a medical history form on file with the University Health Service.

Return this completed Medical Report to Walsh University Health Services.

A MESSAGE CONCERNING YOUR HEALTH

Walsh University's aim is that each student enjoy as complete an experience as is commensurate with his or her physical and mental ability. Your medical history will provide the essential information needed to meet that goal. The history is required primarily to determine what adjustments, if any, must be made in schedules of activities to meet the individual needs of students. Rarely is admission to the University refused for health reasons.

Please note that use of this form makes it unnecessary for you to submit a physician's physical examination report. ***It is most important, therefore, that you complete this questionnaire fully and accurately.***

The University Health Service urges correction of remediable physical defects, including dental and visual, prior to arrival on the campus. Further, immunization and vaccination against tetanus, poliomyelitis, diphtheria, meningitis, hepatitis, and others, as your own physician may advise, are highly recommended before arrival at the University. ***Validation of a measles vaccination is extremely important. This is required by the State of Ohio.***

LAST NAME	FIRST	MIDDLE

DATE OF BIRTH	SOCIAL SECURITY NO.
	☐☐☐ – ☐☐ – ☐☐☐☐

HOME STREET ADDRESS

CITY	STATE	ZIP	HOME PHONE

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY	RELATIONSHIP TO YOU
PARENT'S GUARDIAN'S HOME ADDRESS	HOME PHONE
PARENT'S/GUARDIAN'S BUSINESS ADDRESS	BUSINESS PHONE

COLLEGE LAST ATTENDED	WHEN	SEMESTER YOU PLAN TO ENTER WALSH
		YEAR: 20____ ❑FALL ❑SPRING

SEX	MARITAL STATUS (OPTIONAL)
❑MALE ❑FEMALE	❑SINGLE ❑MARRIED

STATEMENT OF AUTHORIZATION

I authorize the Walsh University Health Services to administer outpatient clinic services and immunizations, to perform emergency procedures as necessary, or to refer to duly licensed medical personnel when indicated, including transfer to outside hospitals.

Also, I authorize any physician, healer, practitioner, clinic, or hospital to furnish to the Walsh University Health Service all information concerning my case history and the treatment, examination, or hospitalization which I received in the past, including copies of hospital and medical records.

I authorize the Health Service to disclose to the Walsh University Physical Education Department such medical information as is required for the sole purpose of placing me into an appropriate physical activity class insofar as my health and physical well-being permit.

I hereby state that I am capable of safely participating in vigorous physical activity offered through physical education, intramural, and intercollegiate athletics unless otherwise noted in this Health Inventory.

SIGNATURE OF STUDENT DATE

SIGNATURE OF PARENT OR GUARDIAN DATE

FAMILY MEDICAL HISTORY

Check the box if any of your BLOOD RELATIVES have had any of the following illnesses.

- ❑ CANCER . . . . ________________
- ❑ HEART DISEASE . . . . ________________
- ❑ HIGH BLOOD PRESSURE . . . . ________________
- ❑ STROKE . . . . ________________
- ❑ TUBERCULOSIS . . . . ________________
- ❑ DIABETES . . . . ________________
- ❑ NERVOUS OR MENTAL DISEASE . . . . ________________
- ❑ ALLERGY, ASTHMA, OR HAY FEVER . . . . ________________
- ❑ CONVULSIONS . . . . ________________
- ❑ BLOOD DISEASE . . . . ________________

Are your parents living? ❑ YES ❑ NO Number of brothers living ______ Number of sisters living ______

List immediate family members who are deceased:

NAME	RELATIONSHIP	AGE AT DEATH	CAUSE OF DEATH
NAME	RELATIONSHIP	AGE AT DEATH	CAUSE OF DEATH
NAME	RELATIONSHIP	AGE AT DEATH	CAUSE OF DEATH

PERSONAL MEDICAL HISTORY

How would you describe your personal health history? ❑ GOOD ❑ FAIR ❑ POOR

If not “good,” please explain: ________________

Have you ever had, or do you presently have, any of the following?

INFECTIOUS DISEASES

COMMENTS:

- ❑ HAD AT AGE ____ ❑ NOW HAVE MEASLES (7-DAY; RUBEOLLA) . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE GERMAN MEASLES (3-DAY; RUBELLA) . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE CHICKEN POX (VARICELLA) . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE CHRONIC OR FREQUENT COLDS . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE MALARIA . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE MENINGITIS . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE MONONUCLEOSIS . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE RHEUMATIC FEVER . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE SCARLET FEVER . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE SEXUALLY TRANSMITTED DISEASES (VENEREAL, SYPHILIS, GONORRHEA) . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE TUBERCULOSIS . . . . ________________
- ❑ HAD AT AGE ____ ❑ NOW HAVE TONSILLITIS . . . . ________________

NAME ______________________________ BIRTHDATE ______________

SKIN AND INTEGUMENT

COMMENTS:

❑ HAD AT AGE ____ ❑ NOW HAVE BREAST TUMOR OR DISCHARGE . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE CYST OR TUMOR . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE SKIN DISEASE OR RASH . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE SORES IN MOUTH/TONGUE/LIPS . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ______________ . . . . ______________________________

EYES, EARS, NOSE AND THROAT

❑ HAD AT AGE ____ ❑ NOW HAVE EAR DISEASE, MASTOID, ETC. . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE HAY FEVER . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE CHRONIC NASAL STUFFINESS . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE NOSE BLEEDS . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE SINUS DISEASE . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE VISUAL PROBLEMS (OTHER THAN WEARING GLASSES) . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ______________ . . . . ______________________________

CARDIOPULMONARY

❑ HAD AT AGE ____ ❑ NOW HAVE ASTHMA . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE COUGHING BLOOD . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE HEART DISEASE . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE HEART MURMUR OR DISEASE . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE HIGH BLOOD PRESSURE . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE PNEUMONIA . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ______________ . . . . ______________________________

GASTROENTERIC

❑ HAD AT AGE ____ ❑ NOW HAVE ABDOMINAL PAIN . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE APPENDICITIS, ACUTE OR CHRONIC . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE FREQUENT DIARRHEA . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE FREQUENT INDIGESTION . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE HEPATITIS/LIVER DISEASE/JAUNDICE . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE PILES OR HEMORRHOIDS . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE ULCER, STOMACH OR DUODENAL . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE ULCERATIVE COLITIS . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE VOMITED BLOOD . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ______________ . . . . ______________________________

GENITOURINARY

❑ HAD AT AGE ____ ❑ NOW HAVE KIDNEY OR BLADDER DISEASE . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE KIDNEY STONE OR BLOOD IN URINE . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE PAINFUL URINATION . . . . ______________________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ______________ . . . . ______________________________

MUSCULOSKELETAL

COMMENTS:

❑ HAD AT AGE ____ ❑ NOW HAVE ARTHRITIS OR RHEUMATISM . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE BACK TROUBLE . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE BONE OR JOINT DEFORMITY . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE FOOT TROUBLE . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE LEG CRAMPS . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE RUPTURE OR HERNIA . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE TRICK KNEE OR LOCKED KNEE . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ________________ . . . . ________________

HEMATOLOGIC

❑ HAD AT AGE ____ ❑ NOW HAVE ANEMIA OR OTHER BLOOD DISEASE . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ________________ . . . . ________________

NEUROPSYCHIATRIC

❑ HAD AT AGE ____ ❑ NOW HAVE DIFFICULTY SLEEPING . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE EPILEPSY . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE HEADACHE (FREQUENT/SEVERE) . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE HEAD INJURY . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE UNCONSCIOUS/COMA (LONGER THAN 5 MINUTES) . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE SHOCK TREATMENTS . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE SUICIDAL TENDENCY OR ACTS . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE DRUG OVERDOSE . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE NEURITIS . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE PARALYSIS OR HANDICAP . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE FREQUENT DIZZINESS OR FAINTING . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ________________ . . . . ________________

METABOLIC

❑ HAD AT AGE ____ ❑ NOW HAVE DIABETES . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE THYROID TROUBLE . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ________________ . . . . ________________

DENTAL

❑ DENTAL EXAMINATION IN PAST 6 MONTHS

❑ HAD AT AGE ____ ❑ NOW HAVE SPECIFIC DENTAL ABNORMALITY . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ________________ . . . . ________________

GENERAL

❑ HAD AT AGE ____ ❑ NOW HAVE EXPOSED TO CONTINUOUS LOUD NOISE . . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE UNEXPLAINED FEVER . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE VARICOSE VEINS . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE WORKED WITH ASBESTOS . . . . ________________

❑ HAD AT AGE ____ ❑ NOW HAVE SCHOOLING INTERRUPTED BY HOSPITALIZATION ________________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ________________ . . . . ________________

FEMALES ONLY:

❑ HAD AT AGE ____ ❑ NOW HAVE PREGNANCY . . . . ____________

❑ HAD AT AGE ____ ❑ NOW HAVE FEMALE DISORDERS . . . . ____________

❑ HAD AT AGE ____ ❑ NOW HAVE PAINFUL OR ABNORMAL PERIODS . . . . ____________

❑ HAD AT AGE ____ ❑ NOW HAVE ON ORAL CONTRACEPTIVES . . . . ____________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ____________ . . . . ____________

MALES ONLY:

❑ HAD AT AGE ____ ❑ NOW HAVE PROSTATE TROUBLE . . . . ____________

❑ HAD AT AGE ____ ❑ NOW HAVE HARD LUMP IN TESTICLE . . . . ____________

❑ HAD AT AGE ____ ❑ NOW HAVE PAINFUL TESTICLE . . . . ____________

❑ HAD AT AGE ____ ❑ NOW HAVE OTHER ____________ . . . . ____________

GENERAL Check each item “NO” or “YES”:

		DATE/AGE	DETAILS
Have you consulted, been treated, or been counseled by a physician, clinic, or other practitioner or specialist in the past five years?	❑NO ❑YES . . .	________	____________
Have you ever had any serious illness, injury, or operation not listed above?	❑NO ❑YES . . .	________	____________
Have you ever been advised to have surgery?	❑NO ❑YES . . .	________	____________
Have you ever been a patient in a hospital or institution?	❑NO ❑YES . . .	________	____________
Have you traveled or resided in any foreign countries?	❑NO ❑YES . . .	________	____________
Have you had a chest X-ray or other X-ray study?	❑NO ❑YES . . .	________	____________
Have you ever been denied life or health insurance?	❑NO ❑YES . . .	________	____________
Have you ever been unable to take physical education, participate in sports, or in vigorous physical activity?	❑NO ❑YES . . .	________	____________
Do you have any condition which could possibly limit your ability to participate in physical education, intramurals, or intercollegiate sports?	❑NO ❑YES . . .	________	____________
Are you now using any medications? (Include injection therapy for allergy.)	❑NO ❑YES . . .	________	____________
Are you allergic or sensitive to any substance or medicine?	❑NO ❑YES . . .	________	____________

IMMUNIZATION RECORD

• M.M.R. (MEASLES, MUMPS, RUBELLA) *Two doses, REQUIRED by Ohio State law*

Dose 1 given at age 12–15 months or later...❑ RECEIVED MO.______ YR._______

Dose 2 given at age 4–6 years or later, and at least one month after first dose...........................❑ RECEIVED MO.______ YR._______

• TETANUS–DIPTHERIA

Primary series of four doses with DTaP or DTP ....#1 ❑ RECEIVED MO.______ YR._______

#2 ❑ RECEIVED MO.______ YR._______

#3 ❑ RECEIVED MO.______ YR._______

#4 ❑ RECEIVED MO.______ YR._______

Tetanus–Diptheria (Td) booster within the last ten years .... ❑ RECEIVED MO.______ YR._______

• POLIO *Primary series in childhood with either injected Salk (IPV) alone, oral Sabine (OPV) alone, or IPV/OPV sequentially*

Primary series of 3 doses, oral Sabine	Primary series of 4 doses, injected Salk	Primary series of IPV/OPV sequential
#1 ❑ RECEIVED MO.______ YR._______	#1 ❑ RECEIVED MO.______ YR._______	IPV #1 ❑ RECEIVED MO.______ YR._______
#2 ❑ RECEIVED MO.______ YR._______	#2 ❑ RECEIVED MO.______ YR._______	IPV #2 ❑ RECEIVED MO.______ YR._______
#3 ❑ RECEIVED MO.______ YR._______	#3 ❑ RECEIVED MO.______ YR._______	OPV #3 ❑ RECEIVED MO.______ YR._______
#4 ❑ RECEIVED MO.______ YR._______	#4 ❑ RECEIVED MO.______ YR._______	OPV #4 ❑ RECEIVED MO.______ YR._______

• VARICELLA *Either a history of chicken pox, a positive Va ricella antibody, or 2 doses of vaccine given at least 1 month apart if immunized after age 13*

History of Disease ❑ YES ❑ NO

Varicella antibody: Month_____/Year_____ Result: ❑ Reactive ❑ Non-reactive

Immunization ....#1 ❑ RECEIVED MO.______ YR._______

#2 ❑ RECEIVED MO.______ YR._______

• HEPITITIS B *Either three doses of vaccine or a positive Hepatitis surface antibody*

Hepatitis B surface antibody: Month_____/Year_____ Result: ❑ Reactive ❑ Non-reactive

Immunization ....#1 ❑ RECEIVED MO.______ YR._______

#2 ❑ RECEIVED MO.______ YR._______

#3 ❑ RECEIVED MO.______ YR._______

• INFLUENZA *Annual immunization recommended to avoid disruption of academic activities*

Immunization ....❑ RECEIVED MO.______ YR._______

• MENINGOCOCCAL *One dose, preferably at entry into college, for freshmen living in dormitories or residence halls who wish to reduce their risk of meningococcal disease. Any undergraduate less than 25 years of age who wishes to reduce their risk of disease should consider the vaccine. Students with immunodeficiency, such as complement deficiency or asplenia, should receive vaccine each 3-5 years.*

Quadrivalent polysaccharide vaccine ....❑ RECEIVED MO.______ YR._______

• TUBERCULOSIS SCREENING *Skin testing should be considered for students in the following categories:*

❑ have signs or symptoms of active tuberculosis disease

❑ have in the last five years visited or lived in a country where tuberculosis is endemic

❑ have a history of HIV infection, IV drug use, diabetes, silicosis, or malignancies

❑ work in a high risk congregate setting such as a nursing home or prison

❑ studying for a career in the health sciences

Tuberculin Skin Test Administered: Month_____/Day_____/Year_____ Read: Month_____/Day_____/Year_____

Result: ______ (actual mm of induyration, transverse diameter; no induration = "0")

Interpretation (based on mm of induration as well as risk factors): ❑ Postive ❑ Negative

Chest x-ray (required if tuberculin skin test is positive) Date of x-ray: Month____/Day____/Year____ Result: ❑ Normal ❑ Abnormal

WALSH UNIVERSITY COUNSELING SERVICES
CONFIDENTIAL

MENTAL HEALTH HISTORY *This page must be completed by the student.*

All information disclosed on this form will be kept confidential. The purpose of this form is to be proactive with linking students to appropriate mental health care on campus or in the surrounding community.

Student Information

LAST NAME	FIRST NAME	MIDDLE
DATE OF BIRTH	SOCIAL SECURITY NO. ☐☐☐-☐☐-☐☐☐☐	
HOME STREET ADDRESS		
CITY	STATE ZIP	HOME PHONE
		CELL PHONE

1. Describe any current or past medical or mental health problems or conditions that have required psychological care. Include dates of treatment.

____

____

____

____

Have you had or experienced any of the following:	NO	YES	DATE/AGE	DETAILS: Include diagnosis and treatment
2. Depression	❐	❐	________	______________________________
3. An anxiety disorder	❐	❐	________	______________________________
4. An eating disorder	❐	❐	________	______________________________
5. Bipolar disorder	❐	❐	________	______________________________
6. Obsessive-compulsive disorder	❐	❐	________	______________________________
7. Anger problems	❐	❐	________	______________________________
8. PTSD Post Traumatic Stress Disorder	❐	❐	________	______________________________
9. ADD/ADHD	❐	❐	________	______________________________

Have you had or experienced any of the following:	NO	YES	DATE/AGE	DETAILS: Include diagnosis and treatment
10. A suicide attempt	❒	❒	________	________________________________
11. Thoughts of suicide	❒	❒	________	________________________________
12. A sleep disorder	❒	❒	________	________________________________
13. Panic disorder/Panic attacks	❒	❒	________	________________________________
14. A learning disability	❒	❒	________	________________________________
Do you have an Individualized Education Plan (IEP)	❒	❒	________	________________________________
15. An anti-social or conduct disorder	❒	❒	________	________________________________
16. Alcohol or substance abuse or dependence	❒	❒	________	________________________________
17. An act of self-mutilation (cutting, branding, etc.)	❒	❒	________	________________________________
18. An unwanted sexual experience	❒	❒	________	________________________________
19. Are you now taking or have you ever taken medication for any of the above?	❒	❒	________	________________________________
20. Have you been hospitalized for a psychiatric disorder?	❒	❒	________	________________________________
21. Have you been treated for alcohol and/or drug addiction?	❒	❒	________	________________________________
22. Are you currently seeing a counselor/psychologist/psychiatrist? Name: ______________________ Phone # ______________________	❒	❒	________	________________________________
23. Have you ever received counseling? Reason: ______________________ Diagnosis: ____________________ Name: ______________________ Phone # ______________________	❒	❒	________	________________________________
24. Do you intend to begin or continue counseling during college?	❒	❒		

Signature ____ Date ____________________________________