STUDENT HEALTH HISTORY FORM (5f)

☒ Downloadable ☒ Trackable

For details about this form or any others, use the Gustavus Enrollment Checklist 2015 at gustavus.edu/go/myd.

Please complete all pages and return directly to Health Service in the envelope provided by August 1, 2016.

Return to: Gustavus Adolphus College | Health Service | 800 West College Avenue | St. Peter, MN 56082
Phone: 507-933-7630 | FAX: 507-933-6074 | health-service@gustavus.edu

CONFIDENTIAL (To be completed by student)

Name: _____ Birth date: ____ / ____ / ____
Last First Middle *Month Day Year*

First name preference: _____ ☐ Male ☐ Female

Permanent address: _____ City: _____

State: _____ Country: _____ ZIP: _____ Phone: (____) _____

Cell phone: (____) _____

Father's name: _____ Home phone: (____) _____

Cell phone: (____) _____ Work phone: (____) _____

Mother's name: _____ Home phone: (____) _____

Cell phone: (____) _____ Work phone: (____) _____

Date entering Gustavus: ____ / ____ / ____ Admission status: Class of 20___ ___ ☐ New Student ☐ Returning ☐ Transfer
Month Day Year

Emergency contact information if different than above:

Name: _____ Relationship: _____

Work phone: (____) _____ Home phone: (____) _____ Cell phone: (____) _____

HEALTH INSURANCE

Please attach a copy of the front and back of your insurance card OR complete the following:

All students are REQUIRED to carry health insurance. Gustavus offers a comprehensive student health insurance plan. All full-time students are automatically enrolled into the plan. In order to decline this coverage, students must complete an on-line waiver verifying other health insurance coverage. More information regarding the policy and the waiver process will be available at June Registration. Insurance coverage will begin August 1st, 2016 and last through July 31st, 2017.

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TO BE COMPLETED BY THE STUDENT

Name: _____ Birth date: ____ / ____ / ____
Last *First* *Middle* *Month* *Day* *Year*

FAMILY HISTORY

HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?

1) Epilepsy
2) Headaches
3) Mental Illness (depression/anxiety/ other)
4) Kidney Disease
5) Diabetes
6) Thyroid Disease
7) Hayfever
8) Asthma
9) Anemia
10) Bleeds Easily
11) Osteoporosis
12) Arthritis
13) Heart Disease
14) Stroke
15) High Blood Pressure
16) High Cholesterol
17) Alcohol/Drug Addiction
18) Hepatitis
19) Cancer
20) Tuberculosis
21) HIV

Mother: _____
Father: _____
Brother: _____
Sister: _____

Father's occupation: _____ Mother's occupation: _____

Please list number of brothers and sisters with their ages: _____

Are you adopted: ☐ Yes ☐ No

With whom do you live? ☐ Parents ☐ Mother ☐ Father ☐ Spouse ☐ Self ☐ Other _____

MEDICAL HISTORY

ALLERGIES: Do you have any allergies to:

Medications (please list) _____

Food _____

Environmental _____

Latex _____

MEDICATIONS TAKEN REGULARLY: (include allergy shots, birth control, pain control, laxatives, vitamins, diet pills, antidepressants, inhalers, etc.)

Name of Provider prescribing medication: _____ Phone: _____

Medication/Dosage: _____

Medication/Dosage: _____

SURGERIES/ACCIDENTS/HOSPITALIZATIONS: _____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

☐ Decreased hearing
☐ Ringing in ear ☐ Ear infections
☐ Dizzy spells ☐ Fainting spells
☐ Vision problems
☐ Severe head injury / concussion
☐ Nose bleeds - *recurrent*
☐ Sinus trouble
☐ Sore throats - *frequent*
☐ Hoarseness - *prolonged*
☐ Hayfever / Allergies
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic cough
☐ Asthma / Wheezing
☐ Shortness of breath:
☐ on exertion ☐ lying flat
☐ Chest pain
☐ High blood pressure
☐ Heart murmur ☐ Swollen ankles
☐ Irregular pulse ☐ Palpitations
☐ Leg pain - *when walking*
☐ High cholesterol
☐ Cold, numb feet or hands
☐ Hair loss
☐ Loss of appetite - *recent*
☐ Difficulty swallowing
☐ Heartburn ☐ Peptic ulcer

☐ *Persistent* nausea / Vomiting
☐ Abdominal pain - *chronic*
☐ Gall bladder trouble
☐ Jaundice / Hepatitis
☐ Diarrhea ☐ Constipation
☐ Diverticulosis ☐ Crohn's /Colitis
☐ Bloody or tarry stools
☐ Hemorrhoids ☐ Hernia
☐ Urinating frequently
☐ with leakage ☐ with pain
☐ Blood in urine ☐ Kidney stones
☐ Urine infections - *frequent*
☐ Sexually transmitted diseases
Type: _____
☐ Weight-loss ☐ Gain - *recent*
☐ Anemia ☐ Bruise easily
☐ Blood transfusions
☐ Mononucleosis
☐ Cancer ☐ Chronic fatigue
☐ Diabetes ☐ Thyroid disease
☐ Seizures ☐ Stroke
☐ Tremor / hands shaking
☐ Numbness / tingling sensations
☐ Headaches - *frequent*
☐ Arthritis / Rheumatism
☐ Back pain - *recurrent*

☐ Bone fracture / joint injury
☐ Foot pain ☐ Tattoos
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Rheumatic fever ☐ Scarlet fever
☐ Polio ☐ Mumps
☐ Measles ☐ German measles
☐ Tuberculosis ☐ Herpes
☐ Aids / HIV ☐ Malaria / tropical diseases
☐ Sleeping or concentration difficulty
☐ Depression ☐ Anxiety
☐ Agitation ☐ Suicidal thoughts
☐ Self injury/cutting ☐ Suicidal attempts
☐ Phobias ☐ Mental illness
☐ Feelings of worthlessness
☐ History of alcohol / drug addiction
☐ Anorexia ☐ Eating disorder
☐ Bulimia
☐ Emotional / physical / sexual abuse

SOCIAL HISTORY:

Do you now or have you ever consumed:

Cigarettes ☐ Y ☐ N Pk./day ___
Alcohol ☐ Y ☐ N Drinks/wk. ___
Caffeine ☐ Y ☐ N Cups/day ___
Street Drugs ☐ Y ☐ N

SPORTS HISTORY: Have you ever…

☐ been restricted from sports or physical exercise?
☐ fainted during exercise?
☐ had chest pain or a racing heart during exercise?
☐ wheezed or coughed during exercise?
☐ had a family member die of sudden death before age 50?
☐ had a concussion?
If yes, how many?_____

MALES: - *Please complete*

☐ Undescended testicle, testicular mass, lump

FEMALES: - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow ___ Length of cycle ___
Date - 1st day of last period
_____
☐ Pain / bleeding during or after sex
Number of:
Pregnancies ___ Abortions ___
Miscarriages ___ Live births ___
Birth control method _____

Other: _____

IMMUNIZATION RECORD

REQUIRED to be completed and returned to Health Service by August 1, 2016.

Name: _____ Birth date: _____ / _____ / _____
Last First Middle *Month Day Year*

REQUIRED IMMUNIZATIONS

Minnesota law requires proof of immunization against Measles, Mumps, Rubella, Tetanus and Diphtheria. You are age exempt for these vaccines if you were born before January 1, 1957. Age exempt? ☐ Yes ☐ No

Please attach a copy of your immunization records.

MMR (Measles, Mumps, Rubella) One dose required after 12 months of age. 1. _____ / _____ / _____ 2. _____ / _____ / _____
Month Day Year *Month Day Year*

TD (Tetanus-Diphtheria booster) One dose required within the **last 10 years**. 1. _____ / _____ / _____ ☐ Td, or ☐ Tdap?
Month Day Year

RECOMMENDED IMMUNIZATIONS

Meningitis 1. _____ / _____ / _____
Month Day Year

Hepatitis A 1. _____ / _____ / _____ 2. _____ / _____ / _____
Month Day Year *Month Day Year*

Hepatitis B 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
Month Day Year *Month Day Year* *Month Day Year*

(HPV) Gardasil 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
Month Day Year *Month Day Year* *Month Day Year*

Varicella–Either a history of chicken pox, two doses of the vaccine given at least one month apart if immunized after age 13, or attach copy of positive varicella antibody. History of illness? ☐ Yes ☐ No

Dates of vaccinations: 1. _____ / _____ / _____ 2. _____ / _____ / _____
Month Day Year *Month Day Year*

History of reaction to immunization? ☐ Yes ☐ No Which immunization? _____

CONSCIENTIOUS / RELIGIOUS EXEMPTION

MUST BE NOTARIZED MUST FILL OUT **ONLY** IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO CONSCIENTIOUS OR RELIGIOUS BELIEF.

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.

_____ _____
Student Signature (or parent or legal guardian if under 18 years of age) *Date*

Subscribed and sworn to me on the _____ day of _____ , 20___ ___.

_____
Signature of Notary

MEDICAL EXEMPTION

MUST BE COMPLETED **ONLY** IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO MEDICAL CONTRAINDICATIONS.

The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

_____ _____
Signature of Medical Professional *Date*

Gustavus Adolphus College
Tuberculosis (TB) Paper Screen
THIS FORM IS TO BE COMPLETED BY THE STUDENT
Return to: Gustavus Health Service, 800 West College Avenue, Saint Peter MN 56082

Name: _____ Date of Birth: _____

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease?	Yes	No
Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)	Yes	No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata.

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above)	Yes	No
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?	Yes	No
Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?	Yes	No
Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol?	Yes	No

If the answer to all of the above questions is NO, no further testing or action is required.

If the answer is YES to any of the above questions, please visit gustavus.edu/healthservice to access the *TB Risk Assessment Form*. Gustavus Adolphus College recommends that you schedule a visit with a health care provider to discuss TB testing and for completion of the *TB Risk Assessment Form*. This visit can be scheduled with your primary care provider at your home clinic or with a provider at the Gustavus Health Service when you get to campus.

**The significance of the travel exposure should be discussed with a health care provider to determine if TB testing indicated*