

# STUDENT HEALTH SERVICE

One Macklem Drive • Wilmore, KY 40390-1198 • Phone: (859) 858-3511, ext. 2277 • Fax: (859) 858-0003

## REPORT OF MEDICAL HISTORY

				M <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	
Last Name (Please print)	First	Middle	Sex	F <input type="checkbox"/>	Married <input type="checkbox"/>	Other <input type="checkbox"/>	Occupation

Home Address (Number and Street)	City	State	Country	Zip Code
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Social Security Number	Date of Birth	Place of Birth	Date you plan to enroll
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In case of emergency contact: \_\_\_\_\_

Name (Please print)	Address	Telephone	Relationship
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### HEALTH INSURANCE: REQUIRED FOR ALL CURRENTLY ENROLLED STUDENTS

Are you covered under your own/family policy? \_\_\_\_\_

Name of Company	Group Number	Policy Number
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PPO / HMO?	Referral needed?	Primary care provider/phone number
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If HMO, strongly recommend a local guest membership physician \_\_\_\_\_

Do you plan to purchase the student health insurance available at time of registration? YES \_\_\_\_\_ NO \_\_\_\_\_

**Please note:** All students are automatically enrolled in the health insurance plan sponsored by the College unless a separate waiver form is signed and submitted to the student accounts office. Information about this plan will be sent in a separate mailing.

**Also note:** All currently enrolled full time students have access to health care at the College Health Service regardless of insurance coverage. Insurance is for services not available at the College Health Service, such as x-rays, lab tests, specialists or hospitalizations.

**REPORT OF MEDICAL HISTORY, page 2** (Student to complete prior to examination by physician)

**FAMILY HISTORY**

Have any members of your family or blood relatives ever had:

YES NO RELATIONSHIP

YES NO RELATIONSHIP

Tuberculosis				Heart Disease			
Diabetes				Kidney Disease			
Emotional Disturbance				Hypertension (High Blood Pressure)			
Cancer				Epilepsy			
Obesity				Any chronic illness not listed			

ALLERGY TO MEDICATION: Penicillin \_\_\_\_\_ Sulfa \_\_\_\_\_ Aspirin \_\_\_\_\_ Others \_\_\_\_\_

**PERSONAL HEALTH HISTORY** (History of previous illness)

√ DATE / Comment

√ DATE / Comment

Measles / German Measles			Dizziness / fainting		
Mumps			High or low blood sugar		
Chicken Pox			High or low blood pressure		
Mononucleosis			Anemia		
Tuberculosis			Gallbladder trouble / gallstones		
Hepatitis			Stomach or intestinal trouble		
Malaria			Back problems		
Ear, nose, throat trouble			Disease or injury to joints		
Seasonal allergies			Tumor or cysts		
Chronic cough			Cancer		
Asthma			Skin rashes / acne		
Recurrent headaches			Pregnancy		
Migraine headaches			Sexually transmitted diseases		
Seizures			Frequent depression / anxiety		
Heart murmur			Behavioral disorders / ADHD		
Pain/pressure in chest			Eating disorder		
Shortness of breath			Insomnia		

Hospitalizations, surgeries, outpatient surgeries? Give date and diagnosis \_\_\_\_\_

Medications taken regularly? \_\_\_\_\_ Allergy injections? \_\_\_\_\_

Medical disability? \_\_\_\_\_ Need special housing? \_\_\_\_\_ Sports participation limited? \_\_\_\_\_

Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? Give details and supply additional medical records if indicated: \_\_\_\_\_

\_\_\_\_\_

**REPORT OF MEDICAL HISTORY, page 3** (*Health Evaluation to be Completed by Medical Provider*)

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_ Pulse \_\_\_\_\_

**REQUIRED LABORATORY**

**Hemoglobin:** \_\_\_\_\_

**Urinalysis:** Sp. Gr.: \_\_\_\_\_ pH: \_\_\_\_\_ Blood: \_\_\_\_\_ Protein: \_\_\_\_\_ Sugar: \_\_\_\_\_ Ketones: \_\_\_\_\_

**REQUIRED IMMUNIZATIONS**

Your health care provider **MUST** complete and sign page 5, *Report of Required Immunization*

- ✓ **MMR** (Measles, Mumps, Rubella) – 2 doses after 12 months of age
- ✓ **DTaP/DT/Td** (diphtheria, tetanus, pertussis) – primary series of at least 4 plus a **Td (or Tdap) within the last 10 years**
- ✓ **Polio** – primary series of at least three
- ✓ **Tuberculosis Skin Test** – **within past six months** (chest x-ray required, if positive)

NORMAL

ABNORMAL

COMMENT

	NORMAL	ABNORMAL	COMMENT
Posture			
Joints			
Speech			
Skin and lymphatics			
Nose and sinuses			
Hearing			
Mouth, throat, tonsils			
Teeth, gums			
Eyes			
Heart			
Lungs and chest			
Abdomen (include hernia)			
Back and spine			
Genito-urinary system			
Endocrine system			
Nutrition			
Nervous system			
Past drug use (indicate nature)			
Emotional problems			
Menstrual cycle			
Pap Smear (optional)			

**REPORT OF MEDICAL HISTORY, page 4** (*Physician Health Evaluation, cont.*)

Is the student on any medication? If so, please list. \_\_\_\_\_

Does the student have any known allergies? \_\_\_\_\_

Physical activity (Physical education classes and activities which may include intramural or intercollegiate sports participation, etc.):

Unlimited \_\_\_\_\_ Limited \_\_\_\_\_ Explain any limitation of physical activity: \_\_\_\_\_

Should the student be followed by the Student Health Service for any specific reason? \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_

In my opinion, the applicant's physical condition is:                      Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Applicant's capacity for normal stresses of college:                      Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

RECOMMENDATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



\_\_\_\_\_  
MEDICAL PROVIDER'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
TELEPHONE

\_\_\_\_\_  
PRINT NAME OF MEDICAL PROVIDER

← (or affix stamp)

## Report of Medical History, page 5

### REQUIRED IMMUNIZATIONS

**\*TO STUDENT:** *This completed form must be submitted prior to registration for your first term at Asbury College.* This requirement may be met in one of two ways. **Please check one box:**

- Have a physician complete this form, which then can be returned by mail or fax to Student Health Services.
- Obtain a copy of your complete immunization record from your high school or Health Department & attach it to your physical form.

#### Student's Information

				- - / /	
Last Name	First Name	Middle Initial	Maiden Name	Social Security Number	Date of Birth

#### Physician's Information *(please read carefully, as boosters may be needed to meet requirements)*

REQUIRED IMMUNIZATIONS	mo / date / year	mo / date / year	mo / date / year	mo / date / year	mo / date / year
A. <b>MMR</b> (measles, mumps, rubella): <i>2 doses required after twelve months of age</i>	#1:	#2:			
B. <b>TETANUS &amp; DIPHTHERIA:</b> 1. <i>Primary series of at least four doses with DtaP or DTP</i> 2. <i>Tetanus-Diphtheria (Td or Tdap) Booster given within last 10 years</i>	#1: #1:	#2:	#3:	#4:	#5:
C. <b>POLIO:</b> <i>Primary series of at least three doses</i>	#1:	#2:	#3:	#4:	#5:
D. <b>REQUIRED TB SKIN TEST (Mantoux PPD), within six months of entry:</b> <i>Previous BCG vaccination does not exempt patient from TB testing</i>					
Date Administered:		Date Read:		Reaction in Millimeters:	_____ mm induration
If positive, chest x-ray required:	Date of Chest X-ray:			Result * ( positive / negative ):	
*Chest x-ray report and follow-up records by health care professional must be attached to Medical History Form.					

RECOMMENDED (NOT REQUIRED) IMMUNIZATIONS	mo / date / year	mo / date / year	mo / date / year
A. <b>HEPATITIS B:</b> <i>Three doses or positive surface antibody</i> 1. Immunization 2. HepB surface antibody <input type="checkbox"/> reactive <input type="checkbox"/> non-reactive	#1:	#2:	#3:
B. <b>MENINGOCOCCAL:</b> <i>One dose recommended for students under age 25, particularly students in residence halls</i> (check one) <input type="checkbox"/> Menomune <input type="checkbox"/> Menactra			

Physician's Name	Signature	Date
Street Address	City	State
	Zip	Telephone
		Fax