SEWANEE
THE UNIVERSITY OF THE SOUTH

University Health Service

HEALTH CARE PROVIDER'S REPORT & FAMILY MEDICAL HISTORY

Student's Name: ____________________ Date of birth: ____________________

Home address: ____

To the student: please complete the other side of this form before taking it to your health care provider.

HEALTH CARE PROVIDER'S REPORT OF PHYSICAL EXAMINATION

To the examining health care provider: Please review the student's history (on the back of this form) and complete the provider's form below, as well as the student's immunization record. Please comment on all positive answers. This student has been accepted — the information supplied will not affect his/her status; it will be used only as a background for providing heath care, if this is necessary. This information is strictly for use of the University Health Service and will not be released without student consent.

Laboratory data (required for all students)

Height ______________ weight ______________ B/P ______________ Pulse ______________

Visual acuity: uncorrected _________ corrected ______________ Circle one: glasses contact lens both

HCP Evaluation

Date of examination ____________________ Name of provider (please print) ____________________

Physical examination is within normal limits: ____ Yes ____ No If abnormal, please explain and attach a copy of your report:

____

Have you treated this student for any significant disease or medical problem other than minor short term illness? ____ Yes ____ No

If so, please explain ____

Is this student currently under your care and on medication? ____ Yes ____ No If so, please explain ____________________

____

Does this student have drug allergies? ____ Yes ____ No If yes, please list ____________________

How can we be of assistance to you in the care of your patient? Attach a copy of evaluation and recommendations, or explain ______________

____

Do you consider this student physically and emotionally capable of handling college academics/life? ____ Yes ____ No ____ Doubtful

If "no" or "doubtful," please give reasons ____

In your opinion is he/she physically qualified for: (please circle) unrestricted restricted athletics, exercise or walking?

If restricted, list basis for restriction ____

Is restriction permanent? ____ Yes ____ No or temporary? ____ Yes ____ No If temporary, for how long? ______________

Does the student have any food allergies? ____ Yes ____ No If yes, please list ____________________

Is the student on a special diet or have other dietary restrictions? ____ Yes ____ No If yes, please explain ______________

____

Signature of examining health care provider ____

Phone (______) ____________________ Fax (______) ____________________

Address ____

City ____________________ State/Zip ____________________

■ *This side to be completed by student before taking to health care provider.*

FAMILY MEDICAL HISTORY

	Age	Occupation	State of health	If deceased, age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

List family history and relationship to you of any disease such as diabetes, hypertension, heart disease, cancer, etc.: ______________________________

____

HEALTH HISTORY

If you have ever had any of the following conditions or symptoms, please place a check mark in the appropriate box.

	ADD/ADHD		Chicken pox (Year?)		High blood pressure		Rheumatic fever
	Anxiety		Depression		Irritable bowel syndrome		Seizures
	Arthritis		Diabetes		Kidney stone		Sexually transmitted disease
	Asthma		Drug/alcohol problem		Malaria		Skin problems
	Back problems		Eating disorder		Migraine headaches		Thyroid problem
	Blood disorder/anemia		Eye injury or disease		Mononucleosis		Tuberculosis
	Bone/joint problems		Frequent headaches		Neurological disorder		Ulcer — stomach or duodenal
	Cancer		Heart murmur		Pneumonia		Urinary infection/problems
	Cardiac problem		Hepatitis (jaundice)		Recurrent bronchitis		Other
	Chest pain/shortness of breath		Hernia		Recurrent sinusitis		

Females only					
	Abnormal pap smear		Breast mass		Female surgery
	Irregular periods		Severe cramps	Are you on medication for cramps or regulation of periods? ___ Yes ___No If so, name:	

Explain conditions checked: ____

____

Are you currently taking any medications? ___ Yes ___ No If so, list names: ______________________________

____

Do you have any drug allergies? ___ Yes ___ No If so, name drug:______________________________

Do you have any other allergies? ___ Yes ___ No If so, explain: ______________________________

Have you ever been admitted to a hospital? ___ Yes ___ No If so, please give date and reason for admission: ______________________________

____

Do you have any physical challenges or conditions that may impact your activity? ___ Yes ___ No If so, explain:______________________________

____

Have you ever had treatment for nervous or emotional problems? ___ Yes ___ No If so, explain: ______________________________

By whom were you treated?______________________________ Address: ______________________________

If medication used for treatment, name:______________________________

Have you ever been treated for an eating disorder? ___ Yes ___ No If so, explain: ______________________________

MENTAL HEALTH HISTORY

Do you have, or have you experienced, any of the following:

Yes	No	Condition	Yes	No	Condition
		Family alcoholism			Recent death of a loved one
		Drug abuse			Feelings of sadness or loneliness
		Pregnancy			Feelings of depression
		Rape or sexual abuse			Difficulty sleeping
		Dating or domestic violence			Difficulty controlling temper

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TUBERCULOSIS RISK & IMMUNIZATION RECORD

Student's Name: ____ Date of birth: ____

Home address: ____

TUBERCULOSIS RISK

To be completed by the student: Please answer all of the TB risk questions. When answering please refer to the list of countries at right that have high rates of tuberculosis.

1. Have you had a positive TB test in the past? ____ Yes ____ No

   If yes, please skip to question 6 — you should not have your TB test repeated.
2. To the best of your knowledge have you had close contact with anyone who was sick with tuberculosis? ____ Yes ____ No
3. Were you born in one of the countries on the list at right? ____ Yes ____ No
4. Have you traveled or lived for more than one month in any of the countries on the list? ____ Yes ____ No
5. If you have answered "yes" to questions 2, 3, or 4 you need to provide documentation of a recent PPD test (within the past year). PPD test date: ______________
6. If a current or past PPD test is positive you will need to obtain a chest x-ray and complete the following information:

   Chest x-ray date: _______________ Results: ____ Positive ____ Negative

   Did you complete 6–9 months of medicine for TB (isoniazid)? ____ Yes ____ No

   If no, please report to the University Health Service upon arrival to campus to discuss preventive (prophylactic) therapy for tuberculosis.

Please have your health care provider complete the other side of this form.

Afghanistan
Angola
Armenia
Azerbaijan
Bahamas
Bahrain
Bangladesh
Belarus
Benin
Bhutan
Bolivia
Bosnia
Botswana
Brazil
Brunei Dar.
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Congo, DR
Cote d'Ivoire
Croatia
Djibouti
Dominican Rep.
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Gabon
Georgia
Ghana
Guam
Guatamala
Guinea
Guinea-Bissau
Guyana
Haiti
Herzegovina
Honduras
Hong Kong SAR
India
Indonesia
Iran
Kazakhstan
Kenya
Kiribati
Korea, DPR
Korea Rep.
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Lithuania
Macao SAR
Macedonia
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia
Moldova Rep.
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Isl.
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Phillippines
Principe
Romania
Russian Federation
Rwanda
Sao Tome
Senegal
Sierra Leone
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Rep.
Tajikistan
Tanzania, UR
Thailand
Togo
Tokelau
Turkmenistan
Uganda
Ukraine
Uzbekistan
Vanuatu
Vietnam
Yemen
Zambia
Zimbabwe

IMMUNIZATION RECORD — *to be completed and signed by health care provider.*

Student's Name: ____ Date of birth: ____

Required immunizations

■ **MMR (measles, mumps, rubella)** — two doses required

1. Dose 1 *(at age 12 mos. or later)* _____/_____/_____ (D M Y)
2. Dose 2 *(at least 28 days after first dose)* _____/_____/_____ (D M Y)

■ **Tetanus, diptheria, pertussis** — tetanus/diptheria (Td) **OR** tetanus/diptheria/pertussis (Tdap) must be within the last ten years.

1. Td *(within the last ten years)* _____/_____/_____ (D M Y)
2. Tdap *(within the last ten years)* _____/_____/_____ (D M Y)

■ **Polio** — if all dates of primary series not known, three primary series are acceptable.

1. OPV alone *(oral Sabin in three doses)*. 1 _____/_____/_____ (D M Y) 2 _____/_____/_____ (D M Y) 3 _____/_____/_____ (D M Y)
2. IPV/OPV sequential. 1 _____/_____/_____ (D M Y) 2 _____/_____/_____ (D M Y) 3 _____/_____/_____ (D M Y) 4 _____/_____/_____ (D M Y)
3. IPV alone *(injected Salk, four doses)*. 1 _____/_____/_____ (D M Y) 2 _____/_____/_____ (D M Y) 3 _____/_____/_____ (D M Y) 4 _____/_____/_____ (D M Y)

■ **Varicella** — history of chicken pox, a positive varicella antibody, or two doses of vaccine (if given after age 13) meets the requirement.

1. History of disease _____Yes _____No Date of disease _____/_____/_____ (D M Y)
2. Varicella antibody _____/_____/_____ (D M Y) Result: _____reactive _____non-reactive
3. Immunization date Dose 1 _____/_____/_____ (D M Y)

   Dose 2 *(given at least 12 weeks after first dose ages 1–12 and at least 4 weeks after first dose if age 13 years or older)* _____/_____/_____ (D M Y)

■ **Hepatitis B** — three doses of Hepatitis B **OR** three doses of Hepatitis A/B vaccine meet the requirement.

1. Hepatitis B Dose 1 _____/_____/_____ (D M Y) Dose 2 _____/_____/_____ (D M Y) Dose 3 _____/_____/_____ (D M Y)
2. Hepatitis A & B combined Dose 1 _____/_____/_____ (D M Y) Dose 2 _____/_____/_____ (D M Y) Dose 3 _____/_____/_____ (D M Y)

■ **Meningococcal (A, C, Y, W-135)** — One dose required as entering freshmen of either Menactra or Menomune.

1. Menactra — preferred) _____/_____/_____ (D M Y)
2. Menomune _____/_____/_____ (D M Y)

Recommended immunizations

■ **Quadrivalent human papilloma virus vaccine (HPV) Gardasil** — Three doses of vaccine for female students 11–26 years of age, at 0, 2, and 6 month intervals. Dose 1 _____/_____/_____ (D M Y) Dose 2 _____/_____/_____ (D M Y) Dose 3 _____/_____/_____ (D M Y)

■ **Hepatitis A** — two doses of Hepatitis A **OR** two doses of Hepatitis A/B vaccine.

1. Hepatitis A Dose 1 _____/_____/_____ (D M Y) Dose 2 _____/_____/_____ (D M Y)
2. Hepatitis A & B combined Dose 1 _____/_____/_____ (D M Y) Dose 2 _____/_____/_____ (D M Y)

Health care provider signature ____ Name (print) ____

Address ____ City___________________________State/Zip ______________________

Phone (______) ____ Fax (______) ____