CLARION
UNIVERSITY

Report of Medical History

PLEASE COMPLETE THIS FORM BEFORE GOING TO YOUR HEALTH CARE PROVIDER FOR EXAMINATION

To the student: You have been accepted. Information you provide will not be used to influence your situation at Clarion University; it will be used, if necessary, solely as an aid to providing necessary health care while you are a student. **This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and written consent.**

Name ______________________ SS# __________ Date of Birth __________
Last Name (print) First M.I.

Address ____
Street City/Town/State Zip

Home telephone ____________ Local telephone ____________ ☐ male ☐ female

Name, relationship, address and telephone of individual to be notified in case of an emergency ______________________________

Citizenship: USA ____ other ____ specify ____ Marital status: ☐ single ☐ married ☐ divorced Veteran: ☐ yes ☐ no

Insurance carrier for hospitalization (company) ____________ policy no. ________ group no. ________

Subscriber's name ______________________ Subscriber's SS# ____________

Family History	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Cancer			
Epilepsy, Convulsions			
Alcoholism/Drug Abuse			

Member	Living	Deceased	Age at death	Cause	Occupation
Father					
Mother					
Siblings					

☐ We would like to share the information on disability with the appropriate university offices. Please check this box if we have your authorization to do so.

Disability (Optional)

Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration from the university? Please describe ______________________________

Personal History

Please answer all questions

Have you had?	Yes	No
hemorrhoids		
bleeding problems		
anemia		
scarlet fever		
chicken pox		
gum/tooth trouble		
sinusitis		
eye, ear, nose, throat trouble		
appendectomy		
tonsillectomy		
hysterectomy (F)		
hernia repair		
thyroid disorder		
pain/pressure in chest		
palpitations (heart)		
heart murmur		
high or low blood pressure		
pneumonia		
chronic cough		
insomnia		
STD		

Have you had?	Yes	No
emotional problems		
alcoholism, drug abuse		
recurrent headache		
recurrent colds		
asthma		
hay fever		
malaria		
tuberculosis		
gall bladder trouble		
recurrent diarrhea		
jaundice		
dizziness, fainting		
albumin, sugar in urine		
diabetes		
weight loss/gain		
hepatitis		
immune disorder		
mononucleosis, Epstein Barr		
tumor, cancer, cyst		
stomach/intestinal		
weakness, paralysis		

Have you had?	Yes	No
head injury/fracture(s)		
skull fracture(s)		
neck injuries		
shoulder injuries		
elbow injuries		
arm/wrist/hand injuries		
rib cage injuries		
hip/knee injuries		
thigh injuries		
lower leg/"shin splints"		
ankle injuries		
foot injuries		
muscle strains (serious)		
false teeth or bridge		
difficulty hearing		
orthopedic surgery		
epilepsy		
pregnancy (F)		
menopause (F)		
abnormal menstrual (F)		
prostate trouble (M)		

I hereby give permission to the University Health Care Provider or to a provider of choice to prescribe necessary medication and/or perform treatments or operations necessary in the best interest of my health needs. I understand that my parents or guardians will be notified of any serious illness or injury at my request.

____
Signature of student Date

Students:
- ☐ Complete medical history form
- ☐ Sign medical history form
- ☐ Take form to physician for exam

Physical Examination

HEALTH CARE PROVIDER: PLEASE COMPLETE ALL SPACES

To the examining health care provider: Please review the student's medical history and complete the physical examination form. Please comment on all positive answers. **This student has been accepted.** The information supplied will not affect his or her admission status; it will be used only as a background for providing health care, if necessary.

All blanks must be completed by answering "yes" or "no" or by supplying the information requested. *Unanswered questions or incomplete answers will delay the registration process by requiring the form to be returned.*

This report is confidential and must be mailed to the **Director, Keeling Health Center, Clarion University of Pennsylvania, Clarion, PA 16214-1232.** The complete record must be on file in the Health Center before health clearance is granted

Last Name (print) ______ First Name ______ Middle ______ Social Security number ______

BP ___/___ height ___ inches ___ weight ___ lbs. ___ LMP ___ (optional) PAP test ___ (optional) Date ___

Corrected vision: Right 20/___ Left 20/___ Uncorrected vision: Right 20/___ Left 20/___

Dates of injections/immunizations must be current

- Td. (within 10 years) ______
- * German Measles ______
- * Mumps ______
- * Measles (need booster) (1) ______ (2) ______
- Polio (last dose) ______

**individuals born in or before 1956 should disregard these requirements*

Tests

TB Mantoux Test (within past year) Lot# ______

Positive ❑ Negative ❑ Date Adm. ______

or

Chest X-ray (if needed)

Positive ❑ Negative ❑ Date ______

Hemoglobin (if indicated) ______

Optional Vaccines (dates)

Meningitis ______

Hep B #1 ______ #2 ______ #3 ______

Are there any abnormalities of the following systems?

	Yes	No	Describe
1. Head, ears, nose, throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Breast			
6. Gastrointestinal			
7. Genitourinary			
Urinalysis			
Sugar			
Albumin			
8. Hernia			
9. Musculoskeletal			
10. Metabolic/endocrine			
11. Neuropsychiatric			
12. Skin			

Medications (list each dosage): ______

Allergies: Medication ______ Environmental ______ Food ______

Major health problems ______

List impaired function of any organ or surgeries ______

Have you any other problems or concerns? ______

Recommendation for physical activity or sports (PE, intramurals, athletics, etc.) unlimited ❑ Limited ❑ explain: ______

Is the student now under treatment for any medical or emotional condition? yes ❑ no ❑ If yes, please explain: ______

Do you have any recommendation regarding the care of this student? yes ❑ no ❑ If yes, please explain: ______

Health Provider Signature ______ telephone number ______

Last Name (print) ______ Address ______

Date ______

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Record is complete ______

Incomplete ______

Immun. Lab. TB Hx Px Insur.

Date ______ Initial ______

HEALTH PROVIDER:

- ❑ Complete physical exam form
- ❑ Is the immunization record complete (if not, please complete)
- ❑ Sign physical exam form