

CONFIDENTIAL

Student:
Please print copies for
your own records.



Holy Family UNIVERSITY

Vice President for Student Services
9801 Frankford Avenue
Philadelphia, PA 19114

Report of Medical History

Must be filled out completely.

Semester/Year

SS#

Last Name (Print)	First Name	Middle	Sex: Male/Female
Home Address	City or Town	State	Zip Code
Home Phone	Cell Phone		Date of Birth
Emergency Contact Person	Phone Number		

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

PERSONAL HISTORY

Please answer all questions. Comment on all positive answers in space below or on additional sheet.

Have you had:	Yes	No		Yes	No
Measles			Frequent Anxiety		
German Measles			Frequent Depression		
Mumps			Worry or Nervousness		
Chicken Pox			Recurrent Headache		
Malaria			Recurrent Colds		
Gum or Tooth Trouble			Head Injury with Unconsciousness		
Sininitis			Hay Fever, Asthma		
Eye, Ear, Nose, Throat Trouble			Tuberculosis		
Surgery			Shortness of Breath		
Appendectomy			Allergy		
Tonsillectomy			Penicillin		
Hernia Repair			Sulfonamides		
Other			Serum		
			Foods (which)		
			Other		

	Yes	No		Yes	No
Pain/Pressure in Chest			Gallbladder Trouble or Gallstones		
Chronic Cough			Recurrent Diarrhea		
Palpitations (Heart)			Rupture, Hernia		
High or Low Blood Pressure			Recent Gain or Loss of Weight		
Rheumatic Fever or Heart Murmur			Dizziness, Fainting, Weakness, Paralysis		
Disease or Injury of Joints: "Trick" Knee, Shoulder, etc.			Venereal Disease		
Back Problems			Albumin/Sugar in Urine		
Tumor, Cancer, Cyst			Frequent Urination		
Jaundice			FEMALE ONLY		
Stomach or Intestinal Trouble			Irregular Periods		
			Severe Cramps		
			Excessive Flow		

	Yes	No
A. Has your physical activity been restricted during the past five years? (Give reasons and durations)		
B. Have you had difficulty with school, studies, or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details)		
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E. Have you consulted or been treated by clinics, physicians, healers or other practitioners, within the past five years?		
F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons)		
G. Do you have any question in regard to your health, family history, or other matters, such as pre-marital counseling, which you would like to discuss now with a member of the staff of the Health Services?		

Remarks or Additional Information

(Use additional sheet if necessary)

Student's Signature

Physician's Signature (Acknowledging Review)

Date



TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. This form will be used only as background to provide health care.

Date of exam: _____ | Height: Feet _____ Inches _____ | Weight _____ lbs | Hearing: Normal _____ | Vision: Normal _____ | BP _____ Pulse _____

Required Immunizations: Immunizations required PRIOR to beginning classes. Please fill in the dates.

	1st	2nd	3rd	4th	5th
MMR - Must have 2 injections, both after 1st birthday & at least 30 days apart					
Polio - Minimum of 3 doses for all students 18 and under					
DPT - 3 or more doses required					
DPT/Tdap/Td - Tetanus booster, must be within last 10 years					
Hepatitis B - Series of 3					
Varicella (chicken pox) - Date of disease OR if no history of disease, 2 doses required after age 13					

Tuberculosis Screening

1. Is the student a member of a high-risk group or is the students entering the health professions? Yes _____ No _____
If no, stop. If yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] Tuberculin containing 5 tuerculin units [TU] intrademally into the volar [inner] surface of the forearm). A history of BCG vaccination should not preclude testing of a member of a high risk group.

2. *Tuberculin Skin Test:* Date given: _____ Date read: _____
Result: _____ (Record actual mm of induration, transverse diameter; if no duration write "0")
Interpretation (based on mm of induration as well as risk factors): positive _____ negative _____

3. *Chest X-Ray* (required if tuberculin skin test is positive): Date given: _____ Result: normal _____ abnormal _____

Meningitis

Vaccine OR waiver is required of all Holy Family University resident students.

Date of Vaccination: _____
Menomune: _____ or Menactra: _____
(Quadrivalent polysaccharide vaccine) (Polysaccharide Diptheria Toxoid Conjugate vaccine)

Meningitis Information Response - Required of all resident students (Check either #1 or #2)

- 1. _____ I have had the meningococcal meningitis immunization.
- 2. _____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided that I will NOT obtain immunization against meningococcal meningitis disease.

SIGNATURE OF STUDENT REQUIRED (OR PARENT/GUARDIAN IF STUDENT IS UNDER AGE 18) _____

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

	Yes	No
1. Head, Ears, Nose, or Throat		
2. Respiratory		
3. Cardiovascular		
4. Gastrointestinal		
5. Hernia		
6. Eyes		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/Endocrine		
10. Neuropsychiatric		
11. Skin		

Is there loss or seriously impaired function of any paired organ? Yes _____ No _____

Have you any general comments?

Recommendation for physical activity: Unlimited _____ Limited _____ Explain _____

Do you have any recommendations regarding the care of this student? Yes _____ No _____

Is the patient now under treatment for any medical or emotional condition? Yes _____ No _____

Physician's Signature _____

Address _____

Print Last Name _____ Date _____

**YOU MUST RETURN ALL INFORMATION
NO LATER THAN THE END OF JULY TO:
Vice President for Student Services**

Holy Family University
9801 Frankford Avenue
Philadelphia, PA 19114-2094