LASALLE UNIVERSITY

DIVISION OF STUDENT AFFAIRS
Counseling and Health Services

Student Health Center Health History Form **2017–18**

STUDENT ID NUMBER: _____

NAME: _____ Start Term: _____ Date of Birth: _____
(Last) (First) (Middle) (month/year) (month/day/year)

CHECK ALL THAT APPLY: ❍ Undergraduate ❍ Graduate ❍ Resident ❍ Commuter ❍ Transfer ❍ International ❍ ELI ❍ Veteran/Military

CLASS ❍ Freshman ❍ Sophomore ❍ Junior ❍ Senior

Completion required of new students in order to register for classes.

Due June 30 for fall semester and Feb. 1 for spring semester.

Healthcare Provider to fill out required vaccines or submit official copies of your vaccines

VACCINE	DATE
MMR (if born after 1956) Two doses **OR** +MMR IGG titer:	
MMR #1 (Measles, Mumps, Rubella):	
MMR #2 (Measles, Mumps, Rubella):	
or **MMR IGG Titer** (positive result):	
Hepatitis B #1:	
Hepatitis B #2:	
Hepatitis B #3:	
Chickenpox (if born after 1979):	
If history of disease—enter date; Varicella IGG titer is recommended for proof of immunity:	
If no disease, then two doses of vaccine are required.	
Varivax vaccine #1:	
Varivax vaccine #2:	

VACCINE	DATE
DPT SERIES (Date series completed):	
Td/TDAP/ADACEL (circle) (Booster in last 10 years):	
Tuberculosis Testing—Must be done in the USA, recommended for all students; only **REQUIRED for students who**:	
• Have lived in or visited high-risk regions such as South America, Central America, Asia, parts of Europe, or Africa.	
• Had contact with a known case.	
Country of Birth: _____	
Country Raised in: _____	
• PPD—date/result/induration _____	
• T-Spot—date/result _____	
• Quantiferon Gold—date/result _____	
If required: USA Chest X-ray date/results _____	

MENINGOCOCCAL MENINGITIS VACCINE (A/C/Y/W-135)
Required by the State of Pennsylvania:

❍ **If initial dose given at under 16 years of age, two doses are required.**
❍ **If initial dose given at 16 years of age or older, one dose is required.**

VACCINE NAME DATE

1: _____

2: _____

❍ **DECLINE**: I have read the information about the Meningococcal Meningitis vaccine. I understand that in declining this vaccine, I continue to be at risk for this serious disease. I can always receive the vaccine at a future time.

_____
Student signature or parent signature if student is under the age of 18 Date

Information Regarding the Option to Decline the Meningitis Vaccine

Meningococcal disease is a serious bacterial illness of the brain and spinal cord. It is a leading cause of bacterial meningitis in children 2-18 years old in the United States. It can cause complications like loss of a limb, deafness, seizures, mental retardation and death. College freshman living in dormitories have an increased risk of getting meningococcal disease.

The best way to prevent the disease is through the Quadravalent (types A, C, W-135, Y) meningococcal vaccine. The State of PA requires college students to either obtain this vaccine or read this information and sign a waiver of refusal. Vaccines cannot prevent all types of this disease but it can significantly reduce your chances. If after reading about this disease you decide to decline it, you must sign the vaccine refusal line on page one of this health form.

There is an additional new meningitis vaccine for type B, which is recommended by the Center for Disease Control, but not required. Discuss this with your doctor. For more information on meningitis visit: cdc.gov/meningitis.

_____
Name of Health Care Provider Signature

_____
Address

_____
City, State, ZIP Phone

FOR STUDENT HEALTH CENTER STAFF ONLY

Complete date _____

Incomplete date _____

PLEASE INFORM PATIENT OF ANY IMMUNIZATION UPDATES NEEDED FOR COMPLETION OF REQUIREMENTS.

NAME: _____ Start Term: _____ Date of Birth: _____
(Last) (First) (Middle) (month/year) (month/day/year)

Students to fill out this information

STUDENT INFORMATION

STUDENT ID NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE NUMBER: _____

STUDENT CELL PHONE NUMBER: _____

BIRTH DATE: _____ SEX: ❍ MALE ❍ FEMALE
(month/day/year)

COUNTRY RAISED IN: _____ COUNTRY OF BIRTH: _____

FAMILY HISTORY

	AGE	HEALTH STATUS (EXCELLENT; GOOD; FAIR; POOR; IF DECEASED, LIST CAUSE OF DEATH)
FATHER:		
MOTHER:		
BROTHERS:		
SISTERS:		

PARENT OR OTHER TO NOTIFY IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COUNTRY: _____ HOME PHONE NUMBER: _____

WORK PHONE NUMBER: _____ CELL PHONE NUMBER: _____

SPECIAL HEALTH REQUIREMENTS

PLEASE IDENTIFY ILLNESS OR CONDITION FOR SPECIALIST CARE: _____

PRIMARY HEALTH CARE PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ FAX: _____

SPECIALIST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ DATE OF LAST VISIT: _____

If you anticipate the need for local medical care from a specialist while on campus, please contact the Student Health Center for referrals.

FAILURE TO COMPLETE THIS HEALTH FORM RESULTS IN A MEDICAL HOLD BLOCKING REGISTRATION FOR CLASSES.

NAME: _____ Start Term: _____ Date of Birth: _____
(Last) (First) (Middle) (month/year) (month/day/year)

Students to fill out this information

MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

A. DRUG AND FOOD ALLERGIES

- ❍ Penicillin/Ampicillin/Amoxicillin
- ❍ Sulfa
- ❍ Codeine
- ❍ Food Allergy (please specify): _____
- ❍ Other (describe): _____
- ❍ **None**

B. NEUROLOGICAL

- ❍ Concussion (list dates): _____
- ❍ Cerebral Palsy
- ❍ Migraines
- ❍ Seizure Disorders Date of last seizure: _____
- ❍ Other (describe): _____
- ❍ **None**

C. CARDIOVASCULAR

- ❍ Fainting
- ❍ Blood Disorder
- ❍ Heart Condition (list): _____
- ❍ Elevated Blood Pressure
- ❍ Heart Murmur
- ❍ Other (describe): _____
- ❍ **None**

D. GASTROINTESTINAL

- ❍ Chronic Inflammatory Bowel Disease
- ❍ Digestive Problems (describe): _____
- ❍ Acid Reflux
- ❍ Other (describe): _____
- ❍ **None**

E. GENITOURINARY

- ❍ Urinary Tract Infections
- ❍ Kidney Stones
- ❍ Kidney Disease
- ❍ Other (describe): _____
- ❍ **None**

F. INFECTIOUS DISEASES

- ❍ **Chicken Pox**
- ❍ Viral Hepatitis
- ❍ Infectious Mononucleosis (Mono)
- ❍ MRSA (Methicillin Resistant Staph Aureus) Date: _____
- ❍ Positive TB testing Date: _____
- ❍ Preventative INH Treatment for Tuberculosis Date: _____
  Length of Treatment: _____
- ❍ HIV
- ❍ Other (describe): _____
- ❍ **None**

G. METABOLIC/ENDOCRINE

- ❍ Diabetes
- ❍ Thyroid Disorder
- ❍ Other (describe): _____
- ❍ **None**

H. RESPIRATORY

- ❍ Asthma/Sports-Induced Asthma
  Asthma Medication: _____
- ❍ Seasonal Allergies: _____
- ❍ Other (describe): _____
- ❍ **None**

I. DERMATOLOGY

- ❍ Eczema
- ❍ Urticaria
- ❍ Psoriasis
- ❍ Other

J. PSYCHOLOGICAL OR SOCIAL

- ❍ Alcohol/Drug Abuse Problems
- ❍ Anxiety
- ❍ Depression
- ❍ Psychiatric Admission
- ❍ Eating Disorder
- ❍ Panic Attack
- ❍ Insomnia
- ❍ ADD/ADHD
- ❍ Other (describe): _____
- ❍ **None**

K. WOMEN'S HEALTH (describe): _____

- ❍ **None**

L. CANCER (describe): _____

- ❍ **None** ❍ **Chemotherapy** ❍ **Radiation**

M. SURGERIES AND HOSPITALIZATIONS

Dates: Specify reason:

_____

_____

_____

N. CHRONIC, SERIOUS, OR OTHER ILLNESS

_____

_____

_____

O. CURRENT MEDICATIONS AND DOSAGES

_____

_____

_____

P. STUDENT HEALTH CENTER ADDITIONS: DATES:

_____

_____