### II. Medical History

#### A. Personal Medical History
- **Allergies**: Medicines, food, latex
- **Diabetes**
- **High Blood Pressure**
- **Alcoholism**
- **Mental or Nervous Disorder**
- **Heart Trouble**

#### B. Family Medical History

#### C. Medications
- **Prescription**
- **Non-Prescription**

#### D. Immunizations
- **MMR**
- **Hepatitis B**
- **Tuberculosis Skin Test**
- **Meningococcal Vaccine**
- **Tetanus (Td)**

### III. Family History

#### Check each item Yes No Relation

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>Year</th>
<th>Check each item</th>
<th>Yes</th>
<th>No</th>
<th>Year</th>
<th>Check each item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies (medicines, food, latex)</td>
<td></td>
<td></td>
<td>10. Gastrointestinal problems</td>
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<td></td>
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<td>19. Psychological counseling</td>
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<tr>
<td>Asthma</td>
<td></td>
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<td>11. Hearing loss</td>
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<td></td>
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<td>20. Respiratory problems</td>
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<tr>
<td>Asthma/bulimia</td>
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<td></td>
<td>12. Heart disease</td>
<td></td>
<td></td>
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<td>21. Rheumatic or other chronic musculoskeletal disorder</td>
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<tr>
<td>Anemia</td>
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<td>13. Hepatitis</td>
<td></td>
<td></td>
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<td>22. Sexually transmitted disease</td>
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<tr>
<td>Attention deficit disorder</td>
<td></td>
<td></td>
<td>14. High blood pressure</td>
<td></td>
<td></td>
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<td>23. Thrombophlebitis and other vein disorders</td>
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<tr>
<td>Childhood</td>
<td></td>
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<td>15. Kidney disease</td>
<td></td>
<td></td>
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<td>24. Urinary tract infections</td>
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<tr>
<td>Depression or anxiety</td>
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<td></td>
<td>16. Menopause</td>
<td></td>
<td></td>
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<td>25. Vitamin or mineral deficiencies (other than dietary)</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>17. Micronutrition</td>
<td></td>
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<td>26. Other</td>
</tr>
<tr>
<td>Epilepsy/convulsions</td>
<td></td>
<td></td>
<td>18. Phenomena</td>
<td></td>
<td></td>
<td></td>
<td>27. Other</td>
</tr>
</tbody>
</table>

#### Have you ever had or do you now have any of the following?

- **Have you ever had a serious illness**?
  - Yes
  - No

- **Have you ever had surgery or been hospitalized**?
  - Yes
  - No

### V. Health Insurance

- **If you are currently covered by a health insurance plan**, please attach a copy of your insurance card (front and back).

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**NOTE:** All students must provide proof of two MMR vaccinations, if born after 1956, or immunity evidence (MMR titer). Other vaccinations are recommended.

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**DO NOT USE LANGUAGE:**

- **MMR**
- **Tuberculosis Skin Test**
- **Meningococcal Vaccine**
- **Tetanus (Td)**

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**Mail to:** Xavier University, McGrath Health and Wellness Center, 3800 Victory Parkway, Cincinnati, Ohio 45207-7611
VII. IMMUNIZATION INFORMATION — The Xavier University requirement is proof of two MMR vaccinations, if born after 1956, or immunity evidence (MMR titer). Other vaccinations are recommended.

A. MMR (Measles, Mumps, Rubella) Two doses of born after 1956. (REQUIRED)

1. Dose 1 given at age 12-15 months or later 9/____/____
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose 9/____/____

B. TETANUS-DIPHTHERIA OR TETANUS-DIPHTHERIA-ACELLULAR-PERTUSSIS (recommended):

1. Date of most recent booster dose 9/____/____
2. Type of booster: Td____ Tdap____

C. HEPATITIS B Three doses of vaccine or a positive Hepatitis surface antibody (recommended)

1. Immunization (HepB)
   a. Dose #1 9/____/____
   b. Dose #2 9/____/____
   c. Dose #3 9/____/____

2. Immunization (Combined Hepatitis A and B Vaccine)
   a. Dose #1 9/____/____
   b. Dose #2 9/____/____
   c. Dose #3 9/____/____

3. Hepatitis B surface antibody Date 9/____/____
   Reaction:  Normal Non-reactive

D. HEPATITIS A

1. Immunization (HepA)
   a. Dose #1 9/____/____
   b. Dose #2 9/____/____

E. VARICELLA Birth in the U.S. before 1980, a positive varicella antibody or two doses of vaccine (recommended)

1. History of disease Yes No
2. Varicella antibody Date 9/____/____
   Reaction:  Normal Non-reactive

Immunization
   a. Dose #1 9/____/____
   b. Dose #2, given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after first dose at age 13 years or older 9/____/____

F. POLIO (Primary series as childhood)

Completion of primary series Date 9/____/____

NOTE: DOCUMENTATION OF UP-TO-DATE IMMUNIZATIONS MUST BE RETURNED BY AUG. 1 TO MAINTAIN YOUR ENROLLMENT.

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G. MENINGOCOCCAL QUADRIVALENT —(A, C, Y, W-135) (strongly recommended) One or two doses for all college students twice every 5 years of increased risk continues

1. Quadsrivalent conjugate (preferred, administer simultaneously with Tdap if possible)
   a. Dose #1 9/____/____
   b. Dose #2 9/____/____

2. Quadsrivalent polysaccharide (acceptable alternative if conjugate not available) Date 9/____/____

H. TUBERCULOSIS SKIN TEST (Required for international students who have arrived within the past 5 years from countries where TB is endemic.)

Date given 9/____/____ Date read 9/____/____

Result:  Normal Abnormal

Interpretation (based on mm of induration as well as risk factors): Positive Negative

Chlor X-ray (required if tuberculin skin test is positive) result:  Normal Abnormal

Date of chest X-ray 9/____/____

I. TYPHOID vaccine (for travel to certain destinations)

Intramuscular Oral

J. HUMAN PAPILLOMAVIRUS VACCINE (HPV2 OR HPV6) Three doses of vaccine for female or male college students; 11-26 years of age at 0, 1-2, and 6-month intervals.

Immunization (indicate which preparation) Quadrivalent (HPV4) or Bivalent (HPV2)

a. Dose #1 9/____/____
   b. Dose #2 9/____/____
   c. Dose #3 9/____/____

Health care provider (MUST BE SIGNED BY HEALTH CARE PROVIDER AND STAMPED WITH OFFICE ADDRESS STAMP)

Name ______________
Address ________________________________
Phone ________________________________
Signature ________________________________

XAVIER UNIVERSITY
McGRATH HEALTH AND WELLNESS CENTER
3800 Victory Parkway, Cincinnati, Ohio 45207-7611