XAVIER UNIVERSITY

STUDENT HEALTH SERVICES

MEDICAL HISTORY

Date _____/_____/ 20_____

Check One: o Undergraduate o Graduate o ESL o International

Year of expected graduation/or length of stay _____.

SECTIONS I-VII TO BE COMPLETED BY THE STUDENT/PARENT

I. Name _____ o M o F Date of birth _____ Place _____
Last First Middle City State Country

Home address _____ Phone _____ Height _____ Weight _____
Number and street City State Zip Cell

Parent, guardian or nearest relative _____ Phone _____ _____ _____
Name Relationship Address Cell Home Work

Family physician _____ Phone _____
Name Address

Specialist _____ Phone _____
Name Specialty Address

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

Check each item	Yes	Year	Check each item	Yes	Year	Check each item	Yes	Year
1. Allergies (medicines, food, latex)			10. Gastrointestinal problems			19. Psychological counseling		
2. Anemia			11. Hearing loss/Recurrent ear problems			20. Concussion / head injury		
3. Anorexia/bulimia			12. Heart disease			21. Rheumatic/scarlet fever		
4. Asthma			13. Hepatitis			22. Sexually transmitted disease		
5. Attention deficit disorder			14. High blood pressure			23. Thyroid problems		
6. Childbirth			15. Kidney disease/stones			24. Urinary tract infection		
7. Depression or anxiety			16. Meningitis			25. Vision problems (contacts/glasses) or other		
8. Diabetes			17. Mononucleosis			26. Tuberculosis		
9. Epilepsy/seizures			18. Pneumonia			27. Other		

III. Family history (parent, grandparent, brother, sister) of the following?

Check each item	Yes	No	Relation	Check each item	Yes	No	Relation
Alcoholism				Mental health			
Diabetes				Tuberculosis			
High blood pressure				Sudden cardiac death			
Heart trouble				Other			

IV. If you answered yes to questions of your health, give details along with corresponding number.

_____

_____

Have you ever had any abnormal **ALLERGIC REACTIONS** to any medications, foods or immunization (penicillin, serum, etc.)?

o No o Yes If yes, explain _____

List any MEDICATIONS you take regularly (dose and schedule):

_____

_____

Have you ever had a serious illness (not listed) or injury? o No o Yes If yes, explain _____

Have you ever had surgery or been hospitalized? o No o Yes If yes, explain _____

V. HEALTH INSURANCE — IF YOU ARE CURRENTLY COVERED BY A HEALTH INSURANCE PLAN, PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK). THIS ACTION DOES NOT FULFILL THE WAIVER PROCESS FOR THE XAVIER STUDENT HEALTH INSURANCE CHARGED TO THE BURSAR.

VI. UNDERAGE STUDENTS — Parent permission for treatment is required for Xavier students under age 18. IF YOU ARE UNDER 18 YEARS OF AGE, PARENTS MUST COMPLETE THIS SECTION: I hereby give permission for the Xavier University Student Health Services to render such diagnostic, therapeutic or minor operative procedures as they deem necessary for my son/daughter.

Signed _____ Date _____/_____/_____
Parent or guardian

RETURN TO: Xavier University, Student Health Services, 3800 Victory Parkway, Cincinnati, Ohio 45207-7611
Phone 513-745-3022 ▌ Fax 513-745-3563 ▌ Return by August 1

Name _____ Date of birth _____

VII. DISCLOSURE OF MENINGOCOCCOL AND HEPATITIS B VACCINATION STATUS — per Ohio Revised Code, section 3701.133, (B). Must complete if you will be living in a campus residence. I, The undersigned student (if 18 years of age or older) or parent (if student is under 18), have read and understand the information provided to me about Meningococcal Meningitis and Hepatitis B. I understand the benefits and risks of being vaccinated against these diseases. The information below regarding my/my student's vaccination status is accurate.

Meningococcal vaccine received: o Yes o No Hepatitis B vaccine received: o Yes o No

Signed _____ Date ____/____/____
Student/Parent or guardian (if student is under 18)

THIS SECTION MUST BE COMPLETED BY A PHYSICIAN

Required

A. **MMR (MEASLES, MUMPS, RUBELLA) REQUIRED (Two doses required at least 28 days apart for students born after 1956.)**
Dose 1 given at age 12 months or later ..... #1 ____/____/____ (M/D/Y)
Dose 2 given at least 28 days after first dose ..... #2 ____/____/____

B. **MENINGOCOCCAL QUADRIVALENT —REQUIRED (one dose on or after 16th birthday. First year and transfer students through 21 years of age must receive.**
Dose 1 ..... #1 ____/____/____ (M/D/Y)
Dose 2 ..... #2 ____/____/____ (M/D/Y)

C. POLIO(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)
1. OPV alone (oral Sabin three doses): ..... #1 ____/____/____ (M/D/Y) #2 ____/____/____ #3 ____/____/____
2. IPV/OPV sequential: ..... IPV #1 ____/____/____ IPV #2 ____/____/____ OPV #3 ____/____/____ OPV #4 ____/____/____
3. IPV alone (injected Salk four doses): ..... #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____

D. VARICELLA (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine.)
1. History of Disease Yes ___ No ___ Date of Documented Disease_____or Birth in U.S. before 1980 Yes ____ No ___
2. Immunization
a. Dose #1 ..... #1 ____/____/____ (M/D/Y)
b. Dose #2 given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after first dose if age 13 years or older ..... #2 ____/____/____ (M/D/Y)

E. TETANUS, DIPHTHERIA, PERTUSSIS
1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/____ (M/D/Y)
2. Date of most recent booster dose: ____/____/____ (M/D/Y) Type of booster: Td _____Tdap _____

F. HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4)(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 ____/____/____ (M/D/Y) b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

G. INFLUENZA
Date of last dose: ____/____/____ (M/D/Y) Trivalent inactivated influenza vaccine (TIV) _____Live attenuated influenza vaccine (LAIV) _____

H. HEPATITIS A
1. Immunization (hepatitis A) ..... a. Dose #1 ____/____/____ b. Dose #2 ____/____/____
2. Immunization (Combined hepatitis A and B vaccine) ..... a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

I. HEPATITIS B
1. Immunization (hepatitis B) ..... a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____
2. Immunization (Combined hepatitis A and B vaccine) ..... a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE (One dose for members of high-risk groups.) Date ____/____/____ (M/D/Y)

K. TYPHOID vaccine (for travel to certain destinations) Injectable ____/____/____ (M/D/Y) or Oral ____/____/____ (M/D/Y)

L. TUBERCULOSIS SKIN TEST (TST is required for international students from countries with a high incidence of TB.)
Most recent date given ____/____/____ (M/D/Y) Date read ____/____/____ (M/D/Y) Result:_____(Record actual mm of induration, transverse diameter; if no induration, write "O")

Interpretation (based on mm of induration as well as risk factors): Positive_____ Negative_____chest x-ray required if TST is positive IGRA date_____result____

Chest X-ray (required if tuberculin skin test is positive) result: Normal_____ Abnormal_____ Date of Chest X-Ray ____/____/____ (M/D/Y)

Healthcare provider
Name _____
Address _____ Phone _____
Number and street City State Zip

Office stamp/signature _____