

# Dickinson College Student Health Services

## MEDICAL/HEALTH HISTORY

P. O. Box 1773 Carlisle, PA 17013

Tel: 717-245-1835

FAX: 717-245-1938

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_

Dickinson E-mail Address \_\_\_\_\_

**STUDENT TO COMPLETE THIS PAPER FORM ONLY IF UNABLE TO COMPLETE ON-LINE FORM THROUGH GATEWAY**

	Yes	No		Yes	No		Yes	No
Anemia			Heart murmur			Positive TB test		
Anorexia or bulimia			Heart valve problem			Psychiatric/Psychologist Care		
Arthritis			Hepatitis or jaundice			Rheumatic fever		
Asthma, wheezing			High blood pressure			Stomach ulcer		
Bleeding disorder			Hospitalized for _____			Surgery for _____		
Cancer			Immunodeficiency disorder			Thyroid disorder		
Glasses / contact lenses			Infectious mononucleosis			Tuberculosis		
Depression			Inflammatory bowel, Crohn's			Serious accidents or injuries		
Diabetes			Kidney or bladder infection, stone			Other _____		
Drug or Alcohol Dependency			Migraine headache			Other _____		
Epilepsy / other seizure disorder			Disabilities _____					

**WOMEN'S HEALTH:** Check boxes to indicate whether you ever had any of these conditions. Provide details at right.

Condition	Yes	No	Details
Removal of breast lump or cyst/breast cancer			
Most recent Pap smear			Date: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

**MEN'S HEALTH:** Check boxes to indicate whether you have ever had any of these conditions. Provide details at right.

Condition	Yes	No	Details
Lump or mass in testicle			

- Current medications (list dosage and directions) \_\_\_\_\_
- Allergies to medication (list) \_\_\_\_\_
- No Known Drug Allergies
- Allergies to foods, insects, environment (list) \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Check each item:	Yes	No	Relationship	Check each item:	Yes	No	Relationship
Tuberculosis				Nervous or mental disorder			
Diabetes				Thyroid disease			
High blood pressure				Cancer			
Heart disease				Mother living			
Alcoholism				Father living			
Liver disease				Lung Disease			
Kidney disease				Gallbladder disease			

**SOCIAL HISTORY (all information is confidential)**

	Yes	No	Frequency		Yes	No	Frequency
Do you smoke cigarettes?			How many/day?	Do you use your seatbelt?			<input type="checkbox"/> never; <input type="checkbox"/> Most of time; <input type="checkbox"/> always
Do you drink alcohol?			How much per week?				
Do you chew tobacco?			How much per week?				

**MENINGITIS VACCINE OR WAIVER – REQUIRED BY PENNSYLVANIA STATE LAW**

- I have had the meningococcal immunization vaccine in accordance with the Pre-Admission Immunization Policy and the date is indicated on the Immunization Record.
- I have read or have had explained to me, information regarding meningococcal disease. I decline the vaccine at this time, but understand if I would like it at a later date, it is my responsibility to contact the Health Center. For information about meningitis go to <http://www.cdc.gov/meningitis/index.htm>.
- I have read or have had explained to me, information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain the immunization against meningococcal disease.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**TUBERCULOSIS (TB) RISK ASSESSMENT**

Have you ever had a <b>positive</b> skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had close contact with anyone who was sick with TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If the country is NOT on the list below, it is considered <i>high-risk</i> for TB</b>		
Were you born in a high-risk country and arrived in the U.S. within the past 5 years? If yes, please indicate the Country _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you traveled to a high-risk country within the past 5 years? If yes, Was duration of travel more than 2 weeks? Date of Travel _____	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
Have you ever been vaccinated with BCG?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**COUNTRIES CONSIDERED LOW RISK FOR TB:**

Albania, America Samoa, Andorra, Antigua and Barbuda, Australia, Austria, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom, U.S. Virgin Islands, U.S.

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- ◀ If the answer is YES to any of the above questions, Dickinson College requires that a health care provider complete the Tuberculosis (TB) Screening form and **testing** in accordance with the CDC guidelines.
  - ◀ If the answer to all the questions is NO, Dickinson College requires that a health care provider complete the the Tuberculosis (TB) Screening form.