



Medical History *(confidential)*

Completion of this form is required prior to receiving any non-emergency health care at the Student Health Center.

The Student Health Center may share pertinent patient information with the University Counseling Center if determined necessary.

Return to:
Truman State University
Student Health Center
100 East Normal
Kirksville, MO 63501-4221

(660) 785-4182

* Please give name as it appears on official University registration _____

*Name: _____ Date of Birth: _____
Last First M mm/dd/yr

Banner/Student ID # _____ Social Security # _____ Phone: Day _____

Permanent Address: _____ Eve _____

_____ Age: _____
City State Country

Marital Status (circle one): Single Married Widowed Divorced Gender: Female Male

In case of emergency, contact: Name _____ Relationship: _____

Phone: Day _____ Eve _____

Family physician: _____ Phone: _____

I will enter in: Fall 20____ Spring 20____ Summer 20____

Class: Freshman International Grad. Student Transfer Other: _____

Personal Health History

Height: _____ Weight: _____

Do you have a present or past history of (check all that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Ear Trouble/Hearing Loss | <input type="checkbox"/> Intestinal/Stomach Trouble | <input type="checkbox"/> Sexually Transmitted Infection |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye Disease (excluding glasses) | <input type="checkbox"/> Joint Disease/Injury | <input type="checkbox"/> Sickle Cell Trait/Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Kidney Infections/Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headache | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia/Rupture | <input type="checkbox"/> Rheumatic Fever | |

Describe any conditions checked above with dates: _____

Current Medications: _____

List DRUG ALLERGIES: _____ While at Truman will you need allergy shots? Yes No
If yes, you must contact the Health Center at (660) 785-4182 prior to your arrival.

Psycho/Social History

Do you have a present or past history of (check all that apply):

- | | | | | |
|---|--|-------------------------------------|---|---------------------------------|
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Bipolar/Mood Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Psychological Counseling | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Drug Use | <input type="checkbox"/> Smokeless Tobacco | |

Describe any conditions checked above with dates: _____

Family Medical History

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

Has any relative (father, mother, sister, brother, or grandparent) suffered from the following:

	Yes	No	Relationship & Comments
Asthma	_____	_____	_____
Drug Allergy	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney Disease	_____	_____	_____
Mental Health Disorders	_____	_____	_____
Genetic Problem	_____	_____	_____
Tuberculosis	_____	_____	_____
Other:	_____	_____	_____

Is there any other information which could be helpful to the health care providers at the Student Health Center?

Health Insurance Information

The Student Health Center does not file insurance for students. Most services at the Student Health Center are provided at no charge to you. However, if you are charged for a service, procedure, or for medications, supplies, or lab work, you will receive a receipt that will enable you to file for insurance. Students are expected to pay for services at the time they are rendered.

Students should bring all pertinent health insurance information with them to Truman State University. This would include a copy of the insurance card, the prescription card if applicable, and a list of any physicians or hospitals in Kirksville that are approved by your PPO/HMO. This will enable the student to more easily use resources outside the Student Health Center if the need arises.

I hereby certify that the above history is complete to the best of my knowledge:

Date: _____ Signature of Student: _____

TO PARENTS OF STUDENTS UNDER AGE 18: I hereby grant permission to the medical staff of the Student Health Center at Truman State University to carry out necessary medical treatment on the above named patient.

Date: _____ Signature of Parent: _____

Truman Immunization Requirements

Please read carefully. Failure to complete as instructed could result in second semester class registration delays.

For questions on completion, please call (660) 785-4182 or e-mail bhiggins@truman.edu

Part I is mandatory for all students. Part II is mandatory for students as indicated.

Send immunization documents directly to the Student Health Center at the address below. Please do not return immunization documents with materials being sent to other university departments.

Student Health Center
Truman State University
McKinney Building
100 E. Normal
Kirksville, MO 63501
Attn: Immunization Policy

-or-

Fax to: (660) 785-4011

-or-

E-mail scanned attachments to:
bhiggins@truman.edu
Please send in jpg or pdf format.

Name: _____	Banner ID#: _____
Address: _____	
Phone #: _____	Date of Birth: Month _____ Day _____ Year _____
E-Mail Address: _____	

Instructions:

Obtain copies of your immunization records and attach to this form. **Students should retain original documents.** Copies of records may be destroyed after entry into the University database. Examples of acceptable documents include:

Copies of personal immunization records ("baby book")

Copies of physician office, Health Department or military immunization records

Copies of high school or previous college immunization records

Part I	Measles, Mumps, Rubella	Required for all students
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Truman State University requires that all newly enrolled or re-admitted students born after December 31, 1956 must comply with the two-dose Measles Immunization Policy. If a second immunization is needed, it must be the combined MMR vaccine. **Students who do not comply will not be allowed to register or pre-register for their second semester classes at Truman.**

Requirement:

2 doses of MMR vaccine. The first dose must have been given at age 12 months or later. The second dose must have been given at least one month after the first one.

OR

1 dose of MMR vaccine AND 1 dose of rubeola at 12 months of age or later. The second dose must have been given at least one month after the first dose.

OR

Titer (blood test) results proving immune status. (Documentation is required.)

Part II	Meningococcal Vaccine	Required for all students living in residence halls
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Missouri legislation requires students in university housing to either: 1) show documentation of meningococcal vaccine **or** 2) sign a waiver that indicates they have been provided educational materials but have chosen not to receive the vaccine at this time. To obtain the waiver for meningococcal vaccine, the pdf may be downloaded and printed from: http://studenthealth.truman.edu/meningitis_form.asp

Part III Tuberculosis (TB) Screening

A. Check any that apply. I:

- am from or have lived for two months or more in Asia, Africa, Central or South America or Eastern Europe.
 have been diagnosed with a chronic medical condition that may impair my immune system.
 am a health care worker.
 am a volunteer or employee of a nursing home, prison or other residential institution.
 have contact with a person known to have active tuberculosis.

If none of the above applies, please indicate: None of the above apply.

B. If any of the above do apply, TB screening is required.

TB Skin Test Screening: (*Two step testing may be medically indicated.*)

OR

Provide documentation of TB screening (PPD Mantoux skin test read and documented in millimeters of induration) done in the U.S. within the pasts 12 months. Chest x-rays will be required for anyone with a positive skin test. A negative chest x-ray is not a substitute for a skin test.

OR

Provide documentation of prior treatment of latent or active TB disease.

Part IV Immunizations recommended, but not required, for all University students.

- Tetanus/Diphtheria administered within the past 10 years.
- Hepatitis B series (3 doses). Even if incomplete, provide dates of any doses received.
- Influenza vaccine. Available each fall and advisable for all students but in particular those with asthma or other chronic illness.
- Varicella (chicken pox). No vaccine is needed if there is a good history of natural infection. If history is questionable, a blood test can be done at the student's expense to determine immune status. If history of chicken pox infection, indicate approximate:
Month _____ Year _____
- Human Papilloma Virus (Gardasil) series (3 doses). Given to females over age 11.

If any of these immunizations have been received, please send a copy of your record along with this form.