Medical History *(CONFIDENTIAL)*

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

As one office administratively, the Student Health Center and University Counseling Services may share information deemed pertinent to client care.

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

(660) 785-4182 PHONE
(660) 785-4011 FAX

* Please provide name as it appears on official University registration

*Name: _____ Date of Birth: _____

Banner/Student ID # _____ Phone: Cell _____

Permanent Address: _____ Home _____

_____ Age: _____

Race: _____

Relationship Status: _____ Gender: _____

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

Phone: Day _____ Eve _____ Cell _____

Family physician: _____ Phone: _____

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

Class: ☐ First Year ☐ International ☐ Grad. Student ☐ Transfer ☐ Other: _____

Personal Health History

Height: _____ Weight: _____

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

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

Describe any conditions checked above with dates or any additional information: _____

_____

Current Medications, including birth control, over-the-counter medications and supplements: _____

_____

List DRUG, FOOD, BEE, LATEX 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):

- ☐ ADD/ADHD
- ☐ Alcohol Use
- ☐ Anxiety Disorder
- ☐ Bipolar/Mood Disorder
- ☐ Eating Disorder
- ☐ Depression
- ☐ Drug Use
- ☐ Psychological Counseling
- ☐ Smokeless Tobacco
- ☐ Smoker
- ☐ Other: _____

Describe any conditions checked above with dates or any additional information: _____

_____

Family Medical History

If adopted, check here ☐

	Age	State of Health	Age at Death	Cause of Death
Biological Father	_____	_____	_____	_____
Biological Mother	_____	_____	_____	_____
Biological Sisters	_____	_____	_____	_____
Biological 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?

_____

_____

_____

_____

Will the Student Health Center be your primary healthcare provider while you are here on campus? ☐ Yes ☐ No

If not, who is/will be your local provider? _____

I hereby affirm that all of the above information supplied on this form is true to the best of my knowledge, and I grant permission to the Truman State University Student Health Center to render medical care that in their judgment is deemed advisable.

Date: _____ Signature of Student: _____

TO PARENTS OF STUDENTS UNDER AGE 18: I hereby grant permission to the Student Health Center at Truman State University to render medical care to my dependent.

Date: _____ Signature of Parent or Guardian: _____

Printed Name/Relationship: _____

Tuberculosis (TB) Screening – Must be completed!

Check any that apply:

I certify that 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.

_____ **have none of the risk factors listed above.**

If any apply, TB Screening with a TB Skin Test is required. Documentation of PPD Mantoux skin test (done in the US within the past 12 months), read and documented in millimeters of induration, must be provided with this document. International students from countries wtih high incidence of tuberculosis will be screened during their first semester with an IGRA blood test. A chest x-ray, completed in the US within 12 months of the first day of classes, will be required for anyone with a positive screening test. A negative chest x-ray is not a substitute for a skin test.

Individuals who have been treated for latent TB infection or active TB disease must provide documentation of adequate treatment as specified by the CDC (Centers for Disease Control).

Consent for E-mail Communication between SHC Staff & Patient

I hereby give my consent for Student Health Center staff members to e-mail me at my Truman e-mail address regarding non-urgent matters, such as appointment reminders, immunization compliance issues, holds on my registration, and notifications that laboratory or radiology results are available. (In no event will the Health Center use electronic communication for identifiable highly sensitive personal health information, such as HIV/AIDS, mental health, or substance abuse due to the nonsecure nature of e-mail.) ☐ *Yes* ☐ *No*

_____ _____

Patient Signature Date

Required Immunizations

1. All students born after Dec. 31, 1956, must comply with Truman's two-dose **MMR (Measles/Mumps/Rubella) Immunization Requirement**. The first dose must have been given at age 12 months or later. The second dose must have been given at least 28 days after the first one. Individuals opting out of this immunization for medical reasons must provide titer results documenting immune status.
2. All students living in University housing must show documentation of **current meningococcal vaccine** given within 5 years of entry to university and after age 16 years. Medical exemptions are allowed with signed statement (by licensed medical physican or nurse practioner) that the immunization would seriously endanger the life or health of the student.

Recommended Immunizations

The following immunizations are recommended, but not required, for all University students. Records of these immunizations should be supplied if available.

- **Tdap** 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 advised for all students.
- **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 Series**. Recommended for students over age 11 years.

Health Insurance Information

Students are required to bring all pertinent health insurance information with them to Truman State University. This would include a copy of the front and back of the medical insurance card and prescription card if applicable. Those with no insurance must so advise Health Center personnel.

CHECKLIST OF ITEMS TO SEND TO STUDENT HEALTH CENTER PRIOR TO MAY 15:

_____ Completed Medical History Form

_____ Insurance Information Sheet

_____ Copy Insurance Card, front & back

_____ Immunization Records