

# CORNERSTONE UNIVERSITY HEALTH SERVICES

## HEALTH HISTORY AND IMMUNIZATIONS

1001 E. Beltline NE, Grand Rapids, MI 49525    PHONE: (616)222-1441, option #2    FAX: (616) 222-1541

*INSTRUCTIONS: Please complete this questionnaire completely and accurately. A physician's physical and dental exam is not required, but strongly recommended. As with all medical information, the confidentiality of your records will be maintained. Please address any questions about this questionnaire or your medical care to the above address or phone.*

LAST NAME (print)	FIRST NAME	MIDDLE	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	DATE OF BIRTH: / /
HOME ADDRESS	CITY	STATE/ZIP	Circle marital status: S M D W		Last 4 digits of SS #: * * * _ * * _
PARENT OR GUARDIAN			RELATIONSHIP		
PARENT/GUARDIAN ADDRESS		P/G HOME PHONE		P/G BUSINESS PHONE:	

### Immunizations

**THIS SECTION IS TO BE COMPLETED BY YOUR PHYSICIAN OR if dates in immunization booklet have HEALTH CARE stamp or signature, a copy may be sent as proof of immunization. A copy of immunization dates may be faxed from your high school, doctor's office or health department.**

	Hepatitis B ***	MMR	Polio	DPT or DTaP	Varicella	Meningo-- coccal**	Travel team	Hepatitis A
Date	1.	1.	1.	1.	1.	1.	Typhoid	1.
Date	2.	2.	2.	2.	2.	2.		2.
Date	3.	3.	3.	3.	<input type="checkbox"/> had chicken pox	3.		3.
Date	4.	Titer	4.	4.	4.	4.	Malaria Rx	4.
Date	5.	Titer	5.	5.	Tetanus Td	5.		5.
TITER	6.	Titer	6.	6.	1.*	6.		6.
	7.	7.	7.	7.	2.	7.		7.

\* A tetanus is required in the last 10 years

\*\* One dose—preferably at entry into college for freshmen living in residence halls who wish to reduce their risk of meningococcal disease.

\*\*\* If 18 years or under, this is required for registration for classes.

<b>TUBERCULOSIS (PPD required <u>regardless</u> of prior BCG inoculation)</b>		
PPD (Mantoux--TB) within the past 12 months (tine or monovac not acceptable) 1. ____ / ____ / ____		
2. Result <input type="checkbox"/> Negative <input type="checkbox"/> Positive    mm induration (horizontal diameter) ____		
If greater than 10 mm induration chest X-ray required	Received BCG:	PPD prior to last 12 months
<input type="checkbox"/> Normal	<input type="checkbox"/> Yes - ____ / ____ / ____	<input type="checkbox"/> Yes ____ / ____ / ____ mm induration (horizontal diameter)
<input type="checkbox"/> Abnormal	<input type="checkbox"/> No	<input type="checkbox"/> No

NAME OF PHYSICIAN OR HEALTHCARE PERSONNEL (print)    ADDRESS    CITY/STATE/ZIP

SIGNATURE OF PHYSICIAN OR HEALTHCARE PERSONNEL    PHONE    FAX

## HEALTH HISTORY

Mark below those health problems you have or have ever had.

<input type="checkbox"/> Allergy Injections <input type="checkbox"/> Acne <input type="checkbox"/> Anorexia Nervosa <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bee Sting Allergy <input type="checkbox"/> Binge Eating <input type="checkbox"/> Blackouts <input type="checkbox"/> Blind <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Emotional/Mental Illness <input type="checkbox"/> Wear Contact Lenses <input type="checkbox"/> Wear Glasses <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Problem	<input type="checkbox"/> Hypertension (high blood pressure) <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Headaches (recurrent) <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Obesity <input type="checkbox"/> Pelvic Infection <input type="checkbox"/> Phlebitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Seizure Disorders (epilepsy) <input type="checkbox"/> Skin Disorder <input type="checkbox"/> Sudden Death in Family <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Teeth (wear braces/splints) <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Viral Hepatitis          Height _____  Weight _____  <input type="checkbox"/> Regular Exercise <input type="checkbox"/> 3 meals a day <input type="checkbox"/> 6-8 hours of sleep a night	Allergies to Medications?   Other Allergies?   Hospitalizations for illness?   Surgeries?   Medications taken regularly?   Other health problems?
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\*\*\*\*\***Please sign Statement of Authorization**\*\*\*\*\*

I authorize the Student Health Services of Cornerstone University to administer medical and surgical services, including immunizations, allergy injections, and to perform routine and emergency diagnostic and therapeutic procedures as deemed necessary by duly licensed medical personnel.

- Signature of student \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of parent or guardian if student under age 18 \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\***Please sign Activity Statement**\*\*\*\*\*

I hereby state that I AM CAPABLE of safely participating in vigorous physical activity offered through physical education, intramural, and intercollegiate athletics, unless otherwise noted in this health history.

- Signature of student \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of parent or guardian if student under age 18 \_\_\_\_\_ Date \_\_\_\_\_

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Attach a copy of the front side of family insurance card here

Attach a copy of the back side of family insurance card here