

Medical History

University of Iowa Student Health Service

The University of Iowa Student Health Service requests this confidential information for the purpose of providing patient care. Persons outside the Student Health Service are not routinely provided this information without the patient's knowledge and written consent. Responses to all items are required in order to facilitate appropriate patient care.

-Label-

A. Personal Data Male Female Other _____

Name: _____ Student I.D.# _____
(Last) (First) (Middle)

Address: _____ Birthdate: _____
(Number, Street or P.O. Box) (City) (State) (Zip)

Emergency Contact Person: _____
(Last Name) (First) (address) (phone)

Preferred name if different from above: _____

B. Personal/Biological Family Medical History Do you or a member of your immediate family have or had any of the following? (Immediate family: Father, Mother, Brothers, Sisters) **Respond to every item. For items marked "Y" make comments in part D**

	You		Family		Relationship		You		Family		Relationship
	Y	N	Y	N			Y	N	Y	N	
Alcohol/Drugs						Hereditary Disease					
Arthritis (disease/injury of joints)						High Blood Pressure					
Asthma						High Cholesterol					
Back Problems						Jaundice or Hepatitis					
Cancer						Kidney Disease					
Convulsive Disorder						Menstrual Irregularity					
Diabetes						Pollen Allergies					
Ear, Nose, Throat problems						Psychiatric Condition					
Epilepsy						Rheumatic Fever					
Eye Disorders (not corrective lenses)						Sexually Transmitted Infection					
Genetic Disorder						Stomach or Intestinal Problems					
Head Injury						Stroke					
Heart Problems/disease						Tuberculosis					
Hemophilia						Weakness or Paralysis					

Have you ever been hospitalized or had surgery? If so, please specify _____

Have you ever had treatment for a mental health condition? _____

List any medications you currently take: (include over the counter meds, contraceptives, herbal drugs, or supplements) _____

List any allergies to: Medications (list type of reaction you had) _____

Food or environmental allergens: _____

C. Social History

1. Do you engage in exercise? yes no (If yes, how often and what form?) _____
2. What is/will be your living arrangement? (e.g. Residence Hall or apartment) _____
3. Do you have any weight or eating concerns? _____
4. Do you know how to protect yourself from sexually transmitted infections? yes no
5. Do you use tobacco? yes no (If yes, indicate how much and for how long.) _____
6. Do you drink alcohol? yes no (If yes, indicate how much and how often.) _____
7. Do you require assistance completing your normal daily activities? yes no (If yes, please describe) _____
8. Do you have any difficulty understanding English? yes no What is your primary language? _____
9. How do you prefer to learn? (check as many as apply) Read ___ Write ___ Listen ___ Observe ___ Perform ___ Other _____
10. Please describe any circumstances that affect your ability to understand and learn about health issues _____
11. If you will require an interpreter or other communication assistance, please inform the scheduler when scheduling your appointment.
12. If you have any Advance Directives, such as a living will, please send a copy with this form.

D. Comments: Use this space to make comments from section B, and for any additional information you feel we should know.

E. Verification:

 Student signature

 Date

Return this form to: The University of Iowa, Student Health Service, 4189 Westlawn, Iowa City, IA 52242-1100 or Fax to 319-335-7247

Immunization Form

University of Iowa Student Health Service

Return this Form to:

THE UNIVERSITY OF IOWA
STUDENT HEALTH SERVICE
4189 Westlawn South
Iowa City, Iowa 52242 OR Fax # 319-335-7247

[Patient label goes here]

Patient's Name _____

Student ID# _____

Address _____

Preferred Name if different from above: _____

IMMUNIZATION INFORMATION BELOW MUST BE VALIDATED WITH THE SIGNATURE OF YOUR PHYSICIAN, NURSE, OR IMMUNIZING OFFICIAL.

*****THIS BOX IS REQUIRED FOR ALL UNIVERSITY OF IOWA STUDENTS*****

Measles, Mumps, Rubella (MMR) - As a public health measure, and in accordance with the Centers for Disease Control Guidelines, The University of Iowa requires verification of MMR immunization for *all students* born after 12/31/1956. Certain colleges have additional requirements (e.g. health science students). Please review your information sheets for your specific requirements.

YOU WILL HAVE ONE SEMESTER TO PROVIDE THE STUDENT HEALTH SERVICE WITH VALIDATION OF YOUR IMMUNITY TO MMR. YOU WILL NOT BE ALLOWED TO REGISTER FOR SUBSEQUENT SEMESTERS UNTIL YOU HAVE COMPLIED.

MMR Proof of immunity to MMR is a requirement for registration and must be validated (see part B below).

This requirement is fulfilled if you meet one of the following criteria:

- were born *before* 1957 OR provide Student Health copies of original lab reports of MMR titres that verify immunity to these diseases OR
- received 2 doses of MMR vaccine:

MMR #1 (month, day, year) ___/___/___ Must be after your 1st birthday, **and in** 1969 or later.

MMR #2 (month, day, year) ___/___/___ Must be at least 28 days after #1 – usually given at age 4-6 years or later.

Note: For a fee, you may get the vaccination at the Student Health Service. Remember you have one semester to comply with the requirement or you will not be allowed to register for subsequent semesters.

*****IMPORTANT PLEASE READ*****

Meningitis is an infection of the fluid surrounding the brain and spinal cord that is caused by a virus or bacteria. Bacterial meningitis can be severe and cause organ damage and death. There are vaccines available that can prevent 4 types of bacterial meningitis, including 2 of the 3 most common in the U.S. Meningitis vaccines cannot prevent all types of the disease. Meningitis vaccine is recommended for college freshmen living in dormitories, and for other adolescents who want to decrease their risk of contracting meningitis. IOWA LAW requires us to provide this information on meningitis and meningitis vaccine. We are also required to collect data on meningitis immunization on our campus.

Please indicate if you have received the meningitis vaccine: yes no; If yes indicate date given (month, day, year): ___-___-___

Your signature verifies that you have read this information. (Signature) _____ (date) _____

Record of tests and immunizations below are encouraged, but not required for most students.

Health Science students are required to provide documentation of all of the immunizations below EXCEPT those that are shaded.

- **Chickenpox (Varicella).** Proof of immunity may be established by having:
 - Had vaccination series - (month, day, year) given: #1 ___/___/___; #2 ___/___/___; OR
 - Had the disease - (month, day, year) ___/___/___
- **Tetanus, Diphtheria & Pertussis (Tdap)** (valid only if within 10 years) - (month, day, year) given ___/___/___; OR
 - Td (valid only if within 10 years) - (month, day, year) given ___/___/___; OR
 - Tetanus (valid only if within 10 years) - (month, day, year) given ___/___/___; AND
 - Diphtheria (valid only if within 10 years) - (month, day, year) given ___/___/___
- **Polio** - date (month, day, year) given: ___/___/___
- **Hepatitis B series** (month, day, year) given: #1 ___/___/___; #2 ___/___/___; #3 ___/___/___; OR
 - Hepatitis B antibody titre. (If so, provide a copy of the original lab report). If non-immune, boosters required according to protocol. OR
 - Hepatitis A/B Combination (month, day, year) given: #1 ___/___/___; #2 ___/___/___; #3 ___/___/___
- **Tuberculin skin test (TST)** (Mantoux 5TU/PPD intradermally only-(*the Tine or HEAF tests are not acceptable*)). TST is valid only if read 48-72 hours from the time it was given.
 - TST given: ___/___/___; date read: ___/___/___; Result: negative positive
(Greater than or equal to 10mm induration) state reaction in mm: _____; OR
 - QuantiFERON TB Gold Test (QFT-G) - (month, day, year) given: ___/___/___; Result: negative positive

* **If your TST/QFT-G is positive, send a copy of your chest X-ray report and treatment record if you have had or are on INH treatment.**

- **HPV series** (month, day, year) given: #1 ___/___/___; #2 ___/___/___; #3 ___/___/___
- **Hepatitis A series** (month, day, year) given: #1 ___/___/___; #2 ___/___/___
- **Sicklelex screening test:** Sickle cell anemia is an inherited disease of people with African or Mediterranean ancestry, which can be detected by a "sicklelex" screening test. I have not had this test; I have had this test, the result was: negative positive

Validation: The signature of your physician, nurse, or immunizing official is required to validate your immunizations/test listed above.

Signature of your physician, nurse, or immunizing official