DOWNSTATE
HEALTH SCIENCES UNIVERSITY

Student Health Center
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PERSONAL MEDICAL HISTORY FORM

*****This form is only for students attending classes remotely/online.*****

Semester Start: ____ Summer ____ Fall ____ Spring Year _____

Program of Study: Select all that apply.

____ School of Public Health ____ School of Health Professions ____ School of Graduate Studies

___ ABA ____ OTD ____ HI

____ MPH ____ MHA ___ MS ____ DrPH ____ Adv. Cert. ____ PhD

____ Other _____

Personal Information:

Name: _____ Gender: _____ SID#: _____

Address: _____ Country of Birth: _____

City, State, Zip Code: _____ Date of Birth: _____

E-mail address: _____ Cell Phone #: _____

Emergency Contact's Name & Phone Number: _____

Proof of Immunity to Measles, Mumps, and Rubella as required by New York State Law.
Submit proof of A) official vaccine record **OR** B) copies of titer lab results.

A) MMR Vaccines: Date of Dose #1 _____ Date of Dose #2 _____

B) Measles Titer: Date: _____ ____ Positive ____ Negative Quant/Numerical Result _____

Mumps Titer: Date: _____ ____ Positive ____ Negative Quant/Numerical Result _____

Rubella Titer: Date: _____ ____ Positive ____ Negative Quant/Numerical Result _____

History of Varicella? ____Yes ____ No

Varicella Titer: Date: _____ ____ Positive ____ Negative Quant/Numerical Result _____

If no history of Varicella or negative titer results, two (2) doses of Varicella vaccine are **REQUIRED.**

Varicella Vaccines: Date of Dose #1 _____ Date of Dose #2 _____

Tuberculin Test: Mantoux Test/PPD **OR** blood-based QUANTiferon Gold Test (within the last 12 months). Attach the PCP's report for the Mantoux test with their signature and license number **OR** copy of the QUANTiferon lab results.

Which test did you complete? ____ Mantoux/PPD ____ QUANTiferon

If your TB test is POSITIVE, you must also submit a chest X-ray (dated within the past 5 years) with a radiologist's assessment.

I certify that the above statements are true and correct to the best of my knowledge.

_____ _____

Student's Signature Date

PERSONAL MEDICAL HISTORY CONTINUED (Completed by student)

Student's Name _____ **Date** _____

	Yes	No	
Blood-Related	☐	☐	Anemia
	☐	☐	Blood disorder/Bleeding trait/SCD
	☐	☐	HIV/AIDS
	☐	☐	Phlebitis
Cardiac	☐	☐	Dizziness/Fainting
	☐	☐	Heart Disease
	☐	☐	High Blood Pressure
	☐	☐	High Cholesterol
	☐	☐	Rheumatic Fever
Gastro-Intestinal	☐	☐	Chronic Inflammatory Bowel Dis. (Crohn's, Ulcerative colitis, etc)
	☐	☐	Digestive Trouble
	☐	☐	Hepatitis
	☐	☐	Peptic Ulcer
Mental Health/ Emotional	☐	☐	ADHD/ADD
	☐	☐	Alcohol or drug use - prob/treatment
	☐	☐	Anxiety or nervousness
	☐	☐	Autism Spectrum Disorder
	☐	☐	Bipolar Disorder/Manic Depression
	☐	☐	Depression
	☐	☐	Eating Disorder: bulimia/anor. nerv.
	☐	☐	PTSD
Neurological	☐	☐	Migraine/recurrent headaches
	☐	☐	Seizure Disorder (epilepsy)
	☐	☐	Head Injury/Concussion
Respiratory	☐	☐	Asthma
	☐	☐	Chronic Bronchitis/Emphysema
	☐	☐	Ear Infection/Hearing Problems
	☐	☐	Hay Fever
	☐	☐	Pneumonia
	☐	☐	Tuberculosis or past positive TB test
	☐	☐	Treatment to prevent TB/for active TB
Urinary/ Reproductive	☐	☐	Breast Disease
	☐	☐	Kidney Disease (congenital/chronic/other)
	☐	☐	Menstrual Problems
	☐	☐	Pregnancy
	☐	☐	Sexually Transmitted Infection
	☐	☐	Urinary Infection
Other	☐	☐	Absent/damage to any paired organs
	☐	☐	Acne (under treatment)
	☐	☐	Arthritis
	☐	☐	Cancer or malignancy
	☐	☐	Cerebral Palsy
	☐	☐	Chicken Pox
	☐	☐	Diabetes Mellitus
	☐	☐	Fracture/Sprain
	☐	☐	Insomnia/Sleep Problems
	☐	☐	Orthopedic Problems/Injuries
	☐	☐	Skin Disorder
	☐	☐	Systemic Lupus
	☐	☐	Thyroid Disorder
	☐	☐	Tobacco Use
	☐	☐	Other: Explain below

If yes to any of the above , explain:

_____

Have you had any surgery? Explain: _____

_____

Have you ever been hospitalized? _____

_____

Other medical concerns (specify): _____

_____

FAMILY MEDICAL HISTORY: Select all that apply, if any.

Parent(s)	Grand Parent(s)	Sibling(s)	
☐	☐	☐	Alcoholism or drug addiction
☐	☐	☐	Bleeding Disorder
☐	☐	☐	Cancer
☐	☐	☐	Heart Disease
☐	☐	☐	High Blood Pressure
☐	☐	☐	Emotional/Mental Illness
☐	☐	☐	Stroke
☐	☐	☐	Sudden death before age 35
☐	☐	☐	Other _____
		☐	None of the above

ALLERGIES AND OTHER SEVERE ADVERSE REACTIONS

☐ No known allergies

☐ Aspirin ☐ Insect/bee sting

☐ Penicillin ☐ Sulfa

☐ Latex ☐ Lidocaine/xylocaine

☐ X-ray contrast ☐ Food

☐ Other (specify)

_____

Please describe allergic reaction: _____

_____

_____

Do you use an EpiPen when you have a reaction: ☐ Yes ☐ No

If yes, do you have an EpiPen? ☐ Yes ☐ No

CURRENT MEDICATIONS: Frequent or Regular – Please select the condition and list name(s) of medications you are currently taking.

☐ Acne	☐ Bowel
_____	_____
☐ ADHD/ADD	☐ Headache
_____	_____
☐ Allergy	☐ Heart Rhythm
_____	_____
☐ Allergy Shots	☐ Insulin
_____	_____
☐ Anti-Depressants	☐ Over-the-counter
_____	_____
☐ Anxiety	☐ Pain
_____	_____
☐ Asthma	☐ Seizure
_____	_____
☐ Birth Control	☐ Thyroid
_____	_____
☐ Blood Pressure	☐ Other (specify)
_____	_____