



Seattle Pacific University

Health Services Medical History Record

Make sure to fill out and send in your medical forms three weeks prior to starting class! They are **required** of all new students and students returning after an absence of more than one calendar year.

If you do not turn in your student immunization record and your medical history record, **you will not be able to register for your second quarter of classes.**

And when you're trying to register, medical forms and immunizations will be the last thing you will want to worry about! So, please follow these directions carefully.

Student Immunization Record *

(separate form, also enclosed)

PART 1 of the Student Immunization Record (also enclosed) is to be filled out by the student.

PART 2 of the Student Immunization Record must be complete and signed or stamped by a *health practitioner*. **A copy of the original Immunization Record is acceptable if a signature is unavailable.** Two MMR vaccinations (measles, mumps, and rubella) given at least one month apart, beginning at or after 12 months of age, are required. A tetanus/diphtheria booster within the last 10 years is required.

PART 3 of the student immunization record is recommended, not required, and is useful when preparing for cross-cultural experience.

PART 4 of the Student Immunization Record is a place to document any travel immunizations you have already had. This Medical History Record will be used

solely for medical purposes and handled only by health professionals concerned about the student's individual health. Information will not be released to anyone without the written consent of the student. Accurate information is important, so please take time to fill out the questionnaire conscientiously.

**General University Requirement*

International Students

All international students are required to complete the Medical History Record and the Student Immunization Record. A tuberculin test (**Note:** tine or monovac is not acceptable) done in the United States within six months of admission is required and may be done at the Health Center the first week of the quarter. International students are required to enroll in the University's student medical insurance plan. Documentation of comparable health insurance coverage from a provider based in the United States or an acceptable reciprocal agreement must be provided to obtain a waiver before the 10th day of the quarter. Waivers must be approved by the Health Center.

To ensure confidentiality, these forms should be returned directly to:
Health Services, Watson Hall, Seattle Pacific University, 3307 Third Avenue West, Suite 110, Seattle, Washington 98119-1922

You can also fax this form to:
206-281-2674

Received

Personal Information

Social Security No. -- Student ID No.

Name _____ Birth Date _____ Sex M F
Last First Middle Former Name

Home Address _____
Street City State Zip/Postal Code

Telephone _____ Former SPU Student Yes No When? _____

Entering: Autumn ___ Winter ___ Spring ___ Year 20 ___ Entering as: (circle one) Fr. So. Jr. Sr. Post-Bacc. Grad.

Health Insurance Provider: Please attach a copy of both sides of your insurance card.

Emergency Contact: _____
Name Relationship

Address _____ Telephone _____
Street City State Zip/Postal Code

Name of Your Physician/Health Care Provider (M.D., N.P., or P.A.C.) _____

Address _____ Telephone _____

City _____ State _____ Zip/Postal Code _____

History of Illness

If you have had any illness listed below, please enter year diagnosed by a health care provider:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Allergies or hay fever | <input type="checkbox"/> Other eye problem | <input type="checkbox"/> Intestinal trouble | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing loss left or right ear | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Knee problem | <input type="checkbox"/> Pilonidal cyst | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Bladder or kidney infection | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Severe head injury | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Concussion | <input type="checkbox"/> Other kidney problem | <input type="checkbox"/> Tumor or cancer |
| <input type="checkbox"/> Serious skin disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Diabetes or sugar in urine | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Arthritis, rheumatism, or bursitis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Bone, joint, or other deformity | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Thyroid underactive or overactive | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shoulder dislocation | <input type="checkbox"/> Lump in breast |
| <input type="checkbox"/> Ear infection | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Loss of body part or function | <input type="checkbox"/> Severe menstrual cramps |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug dependency | <input type="checkbox"/> Ovarian cyst |
| <input type="checkbox"/> Require glasses or contacts | <input type="checkbox"/> Other blood problem | <input type="checkbox"/> Back injury | <input type="checkbox"/> Lump in testicle |
| <input type="checkbox"/> Blind left or right eye | <input type="checkbox"/> Duodenal or stomach ulcer | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Neck injury | <input type="checkbox"/> Other mental illness |
| | <input type="checkbox"/> STD's | | |

Other serious illness or injury not listed: _____

If you are currently receiving treatment for any of the problems you have noted above, please give details: _____

Have you ever had an operation or been hospitalized for any other reason? Yes No

If yes, please give age, where, and why hospitalized: _____

Do you take any medications regularly or frequently? Please list (include nonprescription medications, minerals, herbs, and vitamins) and indicate how frequently you take them: _____

Have you ever had an allergic reaction to a medication? Please list and explain type of reaction (e.g., rash, hives, upset stomach): _____

Do you have any other allergies? (e.g., pollen, foods, environmental allergens, bee stings) _____

Which childhood diseases have you had? (e.g., chicken pox) _____

Do you have any other medical conditions not previously listed? _____

Review of Systems

If you have had any of the symptoms below, please check:

General

- Unexplained or persistent fatigue
- Unexplained weight loss
- Fever or chills
- Night sweats
- Sensitivity to heat or cold
- Frequent or constant thirst
- Dry skin or brittle nails

Ears

- Decreased hearing
- Ringing in ears
- Earaches
- Discharge from ears

Mouth

- Persistent sore tongue
- Persistent sore or bleeding gums
- Frequent canker sores
- Frequent toothache

Respiratory

- Frequent or persistent cough
- Frequent or persistent wheezing
- Frequent or severe shortness of breath

Eyes

- Decreased vision
- Blurred vision
- Double vision
- Persistent pain in eyes
- Itchy, watery eyes

Musculoskeletal

- Swollen or painful joints
- Decreased joint mobility
- Instability of a joint
- Recurrent back pain

Men

- Lump in testicle
- Discharge from penis
- Testicular pain

Digestive

- Frequent nausea or vomiting
- Vomiting blood
- Black tarry feces
- Frequent diarrhea
- Frequent problem with gas
- Frequent or severe or recurrent abdominal pain
- Frequent constipation

Skin

- Rashes
- Changes in pigment, moles
- Changes in hair
- Sore that does not heal

Nose

- Nose bleeds
- Frequent stuffy or runny nose
- Difficulty breathing through nose
- Loss of sense of smell

Throat

- Frequent sore throat
- Frequent or persistent hoarseness

Cardiovascular

- Frequent or severe chest pain or pressure in chest
- Irregular heartbeat, skipped beats
- Swelling of feet or legs
- Racing pulse

Urinary

- Frequent or painful urination
- Blood in urine
- Frequently awakened from sleep to urinate
- Loss of urine control

Women

- Never had a period
- Irregular periods
- Excessive bleeding with periods or prolonged periods
- Bleeding or spotting between periods
- Persistent vaginal itching or unusual discharge
- Lump in breast
- Flank pain

Neurological

- Frequent or severe headaches
- Dizziness or fainting spells
- Difficulty with coordination
- Convulsions or seizures
- Numbness or tingling
- Weakness of arms or legs
- Problem with balance

Have you ever had a positive tuberculin test? Date: _____ Treatment Date: _____

Were you given isoniazide medication? Yes No Date: _____

Date of last tuberculin test or chest X-ray: _____ BCG? Date: _____

Your current height: _____ and weight: _____

Blood pressure if known: _____

Date of last dental exam: _____

Date of last vision check: _____

Date of last hearing check: _____

Date of last PAP test: _____

Family Health

Please check any disease that has occurred to a blood relative (brother, sister, parent, or grandparent):

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental illness | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack before age 60 | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anxiety | |

Are parents or brothers and sisters living and well? Yes No

If no, please give relationship and cause of death: _____

Health Habits

Do you eat regular meals? Yes No

How many meat servings per week? Yes No

Are your meals balanced, containing meat or other protein, dairy products, fruits, vegetables, and whole grain products? Yes No

Are you reducing fat, sugar, salt, and increasing fiber in your diet? Yes No

Are you on a restricted diet prescribed by your physician? Yes No

If so, what diet? _____

Do you exercise regularly at least three times a week and strenuously enough to perspire? Yes No

Do you check your breasts/testicles once a month for lumps? Yes No

Do you currently smoke? If so, how much? _____ Yes No

Do you drink alcohol? If so, how much? _____ Yes No

Do you sleep well and awaken rested? _____ Yes No

Emotional

I often feel sad, guilty, or hopeless about the future. Yes No

I have several good friendships. Yes No

I have previously been diagnosed with anxiety, depression, or other emotional illness. Yes No

If yes, please give brief explanation: _____

Agreement

I understand the hold on registration will not be removed until (1) the **Medical History Record** is turned in and (2) the **Student Immunization Record** is complete with signatures or attached documentation, and is received by Health Services.

Student Signature

Date

Parent or Guardian Signature (if student under 18)

Print Name

For Office Use Only:

DATE REVIEWED

STUDENT INITIAL

CHANGES
