



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

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., bee stings) _____

Which childhood diseases have you had? _____

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

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 | | |

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

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

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

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

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

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: _____
 Were you given isoniazide medication? Yes No Date: _____
 Date of last tuberculin test or chest X-ray: _____
 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: _____

Health Habits

Do you eat regular meals? 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:
 Information still current?

DATE REVIEWED	STUDENT INITIAL	CHANGES
_____	_____	_____
_____	_____	_____
_____	_____	_____