JOHNSON C. SMITH UNIVERSITY
HEALTH SERVICES CENTER
MEDICAL FORM

REPORT OF MEDICAL HISTORY (PLEASE PRINT IN BLACK INK) TO BE COMPLETED BY STUDENT

LAST NAME FIRST NAME MIDDLE NAME STUDENT ID #

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE & PHONE NUMBER

DATE OF BIRTH (MO/DAY/YR) _____ GENDER ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ OTHER

CLASS YOU ARE ENTERING (circle)
FRESH. SOPH. JR. SR. PROF.

PREVIOUSLY ENROLLED HERE ☐
PREVIOUSLY A PATIENT HERE ☐

SEMESTER ENTERING (circle): FALL SPRING
SUMMER OTHER YEAR_____

Hospital/Health Insurance (Name & Address of Company) Area Code & Telephone Number

Name of Policy Holder Employer

Policy or Certificate Number Group Number Is this an HMO/PPO/Managed Care Plan? Yes ☐ No ☐

Name of person to contact in case of an Emergency Relationship

Address City/State Zip Code Area Code & Telephone Number

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require further explanation.

FAMILY & PERSONAL HEALTH HISTORY (Please print in black ink) TO BE COMPLETED BY STUDENT

Has any person related by blood, had any of the following:

	Yes	No	Relationship			Yes	No	Relationship			Yes	No	Relationship
High blood pressure					Cholesterol or blood fat disorder					Cancer (type)			
Stroke					Diabetes					Alcohol/Drug Problems			
Heart attack before age 55					Glaucoma					Psychiatric Illness			
Blood or clotting disorder										Suicide			

Have YOU ever had or have YOU now: (please check at the right of each item and if yes, indicate year of first occurrence)

	Y	N	Year		Y	N	Year		Y	N	Year		Y	N	Year
High Blood Pressure				Allergy Injection / Therapy				Anemia or Sickle Cell Anemia				Severe Menstrual Cramps			
Rheumatic Fever				Concussion				Jaundice				Drug Use			
Heart Trouble				Stomach Ulcer				Hepatitis				Alcohol Use			
Pain/Pressure in chest				Severe Head Injury				Excessive worry or anxiety				Sexually Transmitted Dx.			
Shortness of breath				Migraine Headache(s)				Depression				Anorexia			
Asthma				Intestinal Trouble				Broken Bone				Bulimia			
Pneumonia				Frequent Vomiting				Eye Trouble - other than needing glasses				Blood Transfusion			
Chronic cough				Back Injury				Kidney Infection				Tuberculosis			
Head/Neck radiation treatments				Dizziness or Fainting spells				Gall Bladder Trouble or Gallstones				Smoke 1+ pack cigarettes/week			
Tumor or Cancer				Neck Injury				Bladder Infection				Wear Seat Belt			
Diabetes				Knee Problems				Kidney Stone				Regular Exercise			
Mononucleosis				Hernia				Knee Problems				Sinusitis			
Hay Fever				Hearing Loss				Irregular Periods				"Pink Eye"			

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED (Please print in black ink) **TO BE COMPLETED BY THE STUDENT**

Check each item YES or NO. Every item checked YES must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	YES	NO	EXPLANATION
Penicillin			
Sulfa			
Other Antibiotics (please name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect Bites			
Food Allergies (please name)			
	YES	**NO**	**EXPLANATION**
Do you have any conditions or disabilities that limit your physical activities? (Please describe)			
Have you ever been a patient in any type of hospital? (Specify)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (please describe)			
Other than for a routine check-up, have you seen a physician or healthcare professional in the past six months? (please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify)			

IMPORTANT INFORMATION…PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally reviewed the above information and attest that it is true and completed to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for my self (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service.

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of service. I accept personal responsibility for settling the account with the Cashier and for payment of the incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian, if student under age 18 Date

PHYSICAL EXAMINATION (Please print in black ink) To be completed and signed by physician or clinic

THIS FORM MUST BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT

Last Name, First Name, Middle Initial	**Date of Birth**	**Age**	**Student ID #**

HEIGHT		WEIGHT	
BLOOD PRESSURE		PULSE	
TEMPERATURE		RESPIRATION	
VISION: (RIGHT)		VISION (LEFT)	
GLASSES		CONTACT LENSES	
URINE	SUGAR	ALBUMIN	APPEARANCE
CBC: (Include results if available)	DATE:	NORMAL _____	ABNORMAL _____

	NORMAL	ABNORMAL	COMMENTS
Head			
Eyes			
Ears			
Nose			
Mouth			
Throat			
Neck			
Breast			
Lungs			
Heart			
Abdomen			
Back			
Extremities			
Skin			
Lymphatics			

TO THE PHYSICIAN / NURSE PRACTIONER / PHYSICIAN ASSISTANT

1. Is there loss or seriously impaired function of any paired organs? Yes_____ No_____
EXPLAIN:_____

2. Is applicant under treatment for any medical or emotional condition? Yes_____ No_____
EXPLAIN:_____

3. Does the applicant have any chronic conditions, such as arthritis, diabetes, epilepsy, or heart disease? If yes, explain
_____
_____

4. Recommendation for physical activity (physical education, intramural, etc.) Limited_____ Unlimited_____

5. Is the applicant physically **AND** emotionally healthy? Yes_____ No_____
EXPLAIN_____

_____ _____
Signature of Physician / Physician Assistant / Nurse Practitioner Date

_____ _____
Print Name of Physician / Physician Assistant / Nurse Practitioner Office Address / Stamp

IMMUNIZATION RECORD

Last Name	First Name	Middle Name	Date of Birth	Student ID#

As of July 1, 1986, state law requires all students entering college in the state of North Carolina to meet the immunization requirements described below. **A physician, physician assistant, nurse practitioner, or the health department must verify that the student has the necessary immunizations.** Please type or print information in black ink directly on this form. *(All information must be in English)*

SECTION A Required Immunizations	mo/day/year	mo/day/year	mo/day/year	mo/day/year
* DTP or Td or Tdap	(#1)	(#2)	(#3)	(#4)
***Tdap booster (If due update after 7/2008)**				
*Td booster				
*Polio				
*MMR (after first birthday)				
*Measles/Rubella (MR) Titer date & results				
(REQUIRED IF BORN 07/01/94 OR AFTER) *Hepatitis B series only				****Titer Date & Result
SECTION B Recommended Immunizations				

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Information regarding meningococcal disease can be found at http://www.immunize.nc.gov/family/vaccines/meningococcal.htm Please record on this form, whether or not you have received the meningococcal vaccine.

Meningococcal vaccine: No ( ) Yes ( ) Which vaccine? Menactra ( ) Menomune ( ) Date given:

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
*Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
*Tuberculin Skin Test (PPD) Date read (within 12 months) **Report result in mm indurations**				
Chest X-Ray, if positive PPD Date				
Results				
Treatment if applicable Date				

SECTION C Optional Immunizations	mo/day/year	mo/day/year	mo/day/year
*Haemophilus influenza type b			
*Pneumococcal			
*Hepatitis A series only			
*HPV (Gardasil)			
*Other			

Signature or Clinic Stamp REQUIRED:

_____ _____
Signature of Physician/Physician Assistant/Nurse Practitioner Date

_____ _____
Print Name of Physician/Physician Assistant/Nurse Practitioner Office Address/Stamp

THE COMPLETED FORM MUST BE RETURNED TO:
Health Services Center
Johnson C. Smith University
100 Beatties Ford Road
Charlotte, North Carolina 28216
Ph: 704-378-1075 Fax: 704-378-3530