MEDICAL HISTORY

University of Cincinnati
University Health Service

❑ Undergrad Student
❑ Graduate

NAME _____ SS # _____
last name / family name first middle

ADDRESS _____
street city state zip code

DATE OF BIRTH _____ SEX ____ M____ F COUNTRY OF BIRTH _____

PHONE NUMBER, Home:_____ Local: _____ MARITAL STATUS _____

Note: Your health information is held strictly confidential

FAMILY HEALTH HISTORY

(Parents, Brothers, Sisters, Children)

CHECK EACH ITEM	YES	NO		YES	NO
TUBERCULOSIS			ASTHMA, HAY FEVER, HIVES		
DIABETES			EPILEPSY OR CONVULSIONS		
HIGH BLOOD PRESSURE			NERVOUS OR MENTAL DISEASE		
HEART TROUBLE			DEATH AT YOUNG AGE		
STROKE			SICKLE CELL TRAIT/ANEMIA		
CANCER			OTHER		

PERSONAL HEALTH HISTORY

Have you ever had or have you now any of the following:

CHECK EACH ITEM	YES	NO		YES	NO		YES	NO		YES	NO
Heart Problems			Rupture or hernia			Sinusitis			Kidney, bladder, prostate problem		
High or low blood pressure			Skin diseases, boils			Hay fever, allergy			Diabetes		
Rheumatic fever			Anorexia/bulemia			Asthma			Bone or joint problem		
Scarlet fever			Motion sickness			Reaction or allergy to drugs			Severe headaches		
Cold sores or herpes			Dizzy or fainting spells			Chronic cough			Bleeding disorder		
Diphtheria			Sexually transmitted disease			Shortness of breath			Cancer		
Mumps			Menstrual problem			Stomach or intestinal problem			Sexual problem		
Measles			Surgery in past			Jaundice, liver disease, hepatitis			Alcoholism or drug abuse		
Chickenpox			Hospitalization overnight			Appendicitis			Tobacco use		
Mononucleosis			Nose or throat problem			Epilepsy or convulsions			Sickle Cell Trait/Anemia		
Immune system disease			Ear or eye problem			Nervous problem of any sort			Other Medical problems		

DO YOU CURRENTLY?	YES	NO		YES	NO
Smoke?			See a doctor regularly?		
Wear Glasses or contacts?			Have any physical limitations?		
Take medication?			Have a disability?		
Drink alcohol regularly?			Have religious beliefs that affect your health care?		

If yes, or any other disease, give details:

WORK HISTORY

Past Employment TYPE OF WORK # OF YEARS

_____ _____
_____ _____
_____ _____

Current Employment _____ _____

List any job connected illness or injury _____

_____

Major leisure time activities _____

In case of emergency, please notify _____
(name) (phone #)

_____
(signature) (date)

IMMUNIZATION RECORD

NAME _____ SS# _____ DATE OF BIRTH _____

1. **DIPHTHERIA AND TETANUS TOXOIDS**

All students and staff should have had a basic series of 3 doses of DIPHTHERIA AND TETANUS TOXOIDS. These are usually given with Pertussis (in DTP) in infancy. A booster dose of DIPHTHERIA AND TETANUS TOXOIDS, Adult Type (Td) is needed every 10 years to maintain immunity (see below). If the last dose of the toxoid was received more than 10 years ago, a single booster dose of Td is advised.

BASIC SERIES (Check appropriate box)

❑ Year Completed _____

MOST RECENT BOOSTER	Diphtheria Tetanus (Td)	or	Tetanus Alone (TT)	or	Tdap
Date (month/year)	_____/_____/_____ month day year		_____/_____/_____ month day year		_____/_____/_____ month day year

2. **MEASLES**

Adequate measles vaccination is recommended for all students/staff born after 1956 with no history of physician diagnosed measles. Adequate Measles Immunity is defined as 2 vaccinations with live virus vaccine after your first birthday. *(See below) Many have had only one vaccination during their life or have received a killed virus vaccine (available before 1968). If these criteria for adequate Measles Immunity are not met, revaccination is recommended. If both doses are needed to meet these criteria, they should be at least a month apart.

Dates of Measles Vaccination (month/year)
(LIVE MEASLES VACCINE or MMR Vaccine or MR Vaccine

FIRST DOSE _____/_____/_____ month day year SECOND DOSE _____/_____/_____ month day year

3. **RUBELLA**

Rubella immunity is recommended for all students/staff born after 1956. Adequate rubella immunity is defined as having received Rubella Vaccine or MMR or MR on or after the first birthday. *(See below)

Date of rubella vaccination — (RUBELLA VACCINE or MMR or MR) (month/year): _____/_____/_____ month day year

4. **MUMPS**

Mumps vaccination is recommended for all students/staff born after 1956 with no history of mumps. Adequate mumps vaccination is defined as having received MUMPS Vaccine on or after the first birthday. *(See below)

Date of mumps vaccination — (MUMPS VACCINE or MMR) (month/year): _____/_____/_____ month day year

5. **HEPATITIS B**

1. _____/_____/_____ month day year 2. _____/_____/_____ month day year 3. _____/_____/_____ month day year

***Note:** As long as there is no contraindication to the vaccine. Laboratory evidence of immunity to these diseases is also acceptable proof of "adequate vaccination". If these apply, please explain:

_____

Please record all other immunizations (Polio, Typhoid, Cholera, Typhus, Smallpox, Yellow Fever, Plague, Rabies, BCG, Hepatitis A, Varicella, Influenza, etc.)

_____

Has there been any serious reaction to any immunization? Yes _____ **No** _____
If so, please describe:

_____

_____ _____

(PRINT NAME AND DEGREE OF HEALTH CARE PROVIDER) (SIGNATURE OF HEALTH CARE PROVIDER) DATE