OTTERBEIN UNIVERSITY

STUDENT HEALTH FORM

PLEASE RETURN BY **AUGUST 1** TO:

Otterbein University
Student Health Service
1 South Grove St.
Westerville, Ohio 43081
614-823-1786 (FAX)

☐ Freshman
☐ Sophomore
☐ Junior
☐ Senior
☐ Transfer
☐ Nursing
☐ Graduate

MEDICAL HISTORY

To be completed by student (please print)

Last Name _____ First Name _____ Middle Name _____ (Maiden) _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip Code _____ Phone (Home) _____ (Cell) _____

Date of Birth _____ (Month / Day / Year) Gender ☐ M ☐ F Social Security Number _____ Email Address _____

Emergency Contact _____ (Name) Relationship _____

Address _____ (Street Address) (City) (State) (Zip Code) Phone (Home) _____ (Cell) _____

Among your blood relatives, is there any history of, or present illness of any of the following:

CHECK EACH ITEM	YES	NO	RELATIONSHIP
CANCER			
HEART DISEASE			
HIGH BLOOD PRESSURE			
STROKE			
TUBERCULOSIS			

CHECK EACH ITEM	YES	NO	RELATIONSHIP
DIABETES			
NERVOUS OR MENTAL DISEASE			
ASTHMA OR HAY FEVER			
CONVULSIONS			

☐ Mother Living? ☐ Father living? No. of brothers living ____ No. of sisters living ____

If deceased, give relationship and cause of death _____

Occupation: Father _____ Mother _____

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

CHECK EACH ITEM	YES	NO
ADD/ADHD		
ALLERGIES (DRUGS, OTHER)		
ANEMIA OR BLOOD DISEASES		
ARTHRITIS		
ASTHMA		
BROKEN BONES		
CHICKEN POX		
DEPRESSION		
DIABETES		
DIZZINESS/FAINTING SPELLS		

CHECK EACH ITEM	YES	NO
DRUG OR ALCOHOL ABUSE		
EAR, NOSE, THROAT TROUBLE		
EATING DISORDER		
EPILEPSY/SEIZURES		
EXCESSIVE WORRY/ANXIETY		
FREQUENT/SEVERE HEADACHES		
GALL BLADDER TROUBLE		
HEART DISEASE		
HEPATITIS/JAUNDICE		
HERNIA		

CHECK EACH ITEM	YES	NO
HIGH BLOOD PRESSURE		
INTESTINAL/RECTAL DISEASE		
KIDNEY/BLADDER TROUBLE		
MALARIA		
MEASLES		
MONONUCLEOSIS		
MUMPS		
NERVOUS/MENTAL DISEASE		
PNEUMONIA/CHRONIC COUGH		
RHEUMATIC FEVER		

CHECK EACH ITEM	YES	NO
SEVERE HEAD INJURY		
SEVERE/RECURRENT ABDOMINAL PAIN		
SEXUALLY TRANSMITTED DISEASE		
SINUS DISEASE		
SKIN DISEASE		
THYROID TROUBLE		
TUBERCULOSIS/POSITIVE TB SKIN TEST		
TUMOR/CANCER		

- Are you allergic to or have any sensitivity or intolerance to any medication? ☐ no ☐ yes _____
- Do you regularly take any medication? ☐ no ☐ yes _____
- Have you ever been a patient in any type of hospital? ☐ no ☐ yes _____
- Include any operations and age at which they occurred (state when, where, and why) _____
- Have you ever been hospitalized due to emotional problems? ☐ no ☐ yes
  (if yes, state when, where, and diagnosis) _____
- Have you ever taken an overdose or seriously considered or attempted suicide? ☐ no ☐ yes
- Have you ever been refused employment, unable to hold a job, couldn't take physical education or participate in sports because of your health? ☐ no ☐ yes
- Have you ever had any serious illness, injury or operation not listed above? ☐ no ☐ yes
- If you answered yes to any of the above questions, please give details _____

FOR STUDENTS UNDER 18 YEARS OF AGE, CONSENT FOR HEALTH CENTER TREATMENT TO BE SIGNED BY PARENT OR GUARDIAN

I hereby give my consent for my son/daughter to be treated by the Otterbein University Health Services.

Date _____ Signature _____ Relationship _____

ALL STUDENTS: PLEASE CONSULT YOUR PHYSICIAN ABOUT RECEIVING A MENINGITIS VACCINE.

PHYSICIAN'S EXAMINATION

TO BE COMPLETED BY HEALTH CARE PROVIDER AND RETURNED IN ENVELOPE PROVIDED

Name(Print) _____ Date _____
Last Name First Name Middle Name (Maiden)

1. Sex _____ Height _____ Blood Pressure: _____ BMI: _____
Age _____ Weight _____ Pulse: _____

2. **HEARING:** (optional) Left ___ /15 Right ___ /15

3. **VISION:** (optional) Right 20/ ___ Left 20/ ___ **CORR TO:** Right 20/ ___ Left 20/ ___ Color Vision _____ Test Used _____

CHECK EACH ITEM IN PROPER COLUMN	NORMAL	ABNORMAL
4. HEAD, NECK, FACE AND SCALP		
5. NOSE AND SINUSES		
6. MOUTH, TEETH, GINGIVA, AND THROAT		
7. EARS GENERAL (CANALS, DRUMS, ETC.)		
8. EYES GENERAL (LIDS, PUPILS, MOTIONS, ETC.)		
9. LUNGS, CHEST, AND BREASTS		
10. HEART		
11. VASCULAR SYSTEM (INCLUDE VARICOSITIES)		
12. ABDOMEN AND VISCERA (INCLUDE HERNIA)		
13. ANO-RECTAL AND PILONIDAL		
14. ENDOCRINE SYSTEM		
15. GENITO-URINARY SYSTEM		
16. UPPER EXTREMITIES		
17. LOWER EXTREMITIES		
18. SPINE, OTHER MUSCULO-SKELETAL		
19. SKIN AND LYMPHATICS		
20. NEUROLOGICAL SYSTEM		
21. PSYCHIATRIC (PERSONALITY DEVIATION, ETC.)		
22. IF FEMALE, GIVE MENSTRUAL HISTORY		

NOTE: Give details of each abnormality. Enter corresponding item number before each comment.

23. ANY SPECIAL TESTS USED FOR YOUR CLINICAL EVALUATION? (BLOOD, EKG, ETC.)

24. Should physical education or intramural activities be restricted?
YES_____ NO_____
If limited, please explain _____

THIS FORM IS REQUIRED TO BE COMPLETED BY ALL INCOMING FULL-TIME STUDENTS, ATHLETES AND NURSING.

Return this form to: Otterbein University
Student Health Center
1 South Grove Street
Westerville, OH 43081
P (614) 823-1345
F (614) 823-1786

REQUIRED FOR ADMISSION

IMMUNIZATION HISTORY- RECORD ALL DATES

TDaP _____
(Tet/Diph/Pert required in last 10 years)

Polio #1_____#2_____#3_____ #4_____ **OR**
(copy of titer must be submitted)

Measles/Mumps/Rubella (MMR): 2 required
#1_____ #2 _____ **OR**
(copy of titer must be submitted)

REQUIRED FOR ALL STUDENTS:
TUBERCULIN SKIN TEST: **IN PAST 12 MOS.**
Date: _____

MANTOUX ONLY NEG. _____ POS. _____
(If positive, a chest x-ray is required with results submitted)

Meningitis vaccine (Recommended): _____

In addition to above:
ATHLETES (required): Sickle Cell Testing Neg___Trait___Disease___

In addition to above:
NURSING (required): A Tuberculin skin test, a 2-step Mantoux, is required. The second step MUST be given between 7 and no longer than 14 days after the first step.

Date - 1st skin test_____ Reaction_____ Date read: _____

Date - 2nd skin test_____ Reaction_____ Date read: _____

Varicella:

Dates of (2) vaccine 4-8 weeks apart _____ _____

OR Varicella Antibody IgG titer required for students with a history of chicken pox. Date of titer_____ Results_____

Hepatitis B vaccine:

Dates of series #1_____#2_____#3_____

OR Quantitative HBSAb titer. Date of titer_____ Results_____
(Copy of all titers must be submitted)

Influenza vaccine: _____

_____
Physician Signature

_____
Street Address

_____
City, State, Zip

_____
Phone (include area code)

_____
Physician's Name *please print or stamp*