



STUDENT HEALTH FORM

Please return by May 1 TO:

Otterbein University
 Department of Nursing
 NursingHealthReqs@Otterbein.edu

- 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 _____ Gender M F Social Security Number _____ Email Address _____
 Month / Day / Year
 Emergency Contact _____ Relationship _____
 Name _____
 Address _____ Phone (Home) _____
 Street Address _____ City _____ State _____ Zip Code _____ (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	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
ADD/ADHD			DRUG OR ALCOHOL ABUSE			HIGH BLOOD PRESSURE			SEVERE HEAD INJURY		
ALLERGIES (DRUGS, OTHER)			EAR, NOSE, THROAT TROUBLE			INTESTINAL/RECTAL DISEASE			SEVERE/RECURRENT ABDOMINAL PAIN		
ANEMIA OR BLOOD DISEASES			EATING DISORDER			KIDNEY/BLADDER TROUBLE			SEXUALLY TRANSMITTED DISEASE		
ARTHRITIS			EPILEPSY/SEIZURES			MALARIA			SINUS DISEASE		
ASTHMA			EXCESSIVE WORRY/ANXIETY			MEASLES			SKIN DISEASE		
BROKEN BONES			FREQUENT/SEVERE HEADACHES			MONONUCLEOSIS			THYROID TROUBLE		
CHICKEN POX			GALL BLADDER TROUBLE			MUMPS			TUBERCULOSIS/POSITIVETB SKIN TEST		
DEPRESSION			HEART DISEASE			NERVOUS/MENTAL DISEASE			TUMOR/CANCER		
DIABETES			HEPATITIS/JAUNDICE			PNEUMONIA/CHRONIC COUGH					
DIZZINESS/FAINTING SPELLS			HERNIA			RHEUMATIC FEVER					

- 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:** Left ___/15 Right ___/15
(optional)

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

CHECK EACH ITEM IN PROPER COLUMN	NORMAL	ABNORMAL	REQUIRED FOR ADMISSION
4. HEAD, NECK, FACE AND SCALP			IMMUNIZATION HISTORY- RECORD ALL DATES
5. NOSE AND SINUSES			TDaP _____ (Tet/Diph/Pert required in last 10 years)
6. MOUTH, TEETH, GINGIVA, AND THROAT			Polio #1 _____ #2 _____ #3 _____ #4 _____ OR (copy of titer must be submitted)
7. EARS GENERAL (CANALS, DRUMS, ETC.)			Measles/Mumps/Rubella (MMR): 2 required #1 _____ #2 _____ OR (copy of titer must be submitted)
8. EYES GENERAL (LIDS, PUPILS, MOTIONS, ETC.)			REQUIRED FOR ALL STUDENTS: TUBERCULIN SKIN TEST: IN PAST 12 MOS. Date: _____
9. LUNGS, CHEST, AND BREASTS			MANTOUX ONLY NEG. _____ POS. _____ (If positive, a chest x-ray is required with results submitted)
10. HEART			Meningitis vaccine (Recommended): _____
11. VASCULAR SYSTEM (INCLUDE VARICOSITIES)			In addition to above: ATHLETES (required): Sickle Cell Testing Neg ___ Trait ___ Disease ___
12. ABDOMEN AND VISCERA (INCLUDE HERNIA)			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 - 1 st skin test _____ Reaction _____ Date read: _____ Date - 2 nd 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: _____
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
 Department of Nursing
 NursingHealthReqs@otterbein.edu

 Physician Signature

 Street Address

 City, State, Zip

 Phone (include area code)

 Physician's Name *please print or stamp*