Coastal Carolina University • Student Health Services • Health History Form

Last name (print) ____________ First ____________ Middle ____________

Today's date ____________ Social Security number ____________

Permanent address ____________

City ____________ State/Country ____________ Zip code ____________

Telephone number (______) ____________ Date of birth ____________ ☐ Male ☐ Female

Emergency contact: Name ____________ Relationship ____________

Address ____________

Emergency contact telephone (______) ____________ Business telephone (______) ____________

Marital status ____________ Month/year you are entering the University____________

Health insurance company name ____________ Telephone (______) ____________

Policy holder's name ____________ Policy number ____________

Are you ALLERGIC to any of the following?

☐ Yes ☐ No MEDICATIONS: If yes, name ____________

☐ Yes ☐ No FOOD: If yes, name ____________

☐ Yes ☐ No INSECT VENOM: If yes, name ____________

☐ Yes ☐ No POLLEN, DUST, MOLD, ANIMALS: If yes, name ____________

☐ Yes ☐ No OTHER ____________

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

	Yes	No	Relationship
Tuberculosis	☐	☐	
Diabetes	☐	☐	
Kidney Disease	☐	☐	
Heart Disease	☐	☐	
Thyroid Problems	☐	☐	
Cancer	☐	☐	
Asthma	☐	☐	
Depression/Drug/Alcohol	☐	☐	
Seizures	☐	☐	

HAVE YOU HAD	YES	NO
Anemia	☐	☐
Back Problems	☐	☐
Gall Bladder Trouble	☐	☐
Jaundice	☐	☐
Palpitations	☐	☐
Rheumatic Fever	☐	☐
Rubella	☐	☐
Weight Changes	☐	☐
MALES ONLY		
Testicular Mass	☐	☐
Prostate Infection	☐	☐

HAVE YOU HAD	YES	NO
Anxiety	☐	☐
Bone Disease	☐	☐
Headaches	☐	☐
Insomnia	☐	☐
Chest Pains	☐	☐
Heart Murmurs	☐	☐
Stomach Troubles	☐	☐
STDs	☐	☐
FEMALES ONLY		
Menstrual problem	☐	☐
Endometriosis	☐	☐

HAVE YOU HAD	YES	NO
Asthma	☐	☐
Cancer	☐	☐
Hypertension	☐	☐
Mumps	☐	☐
Recurrent Diarrhea	☐	☐
Surgery	☐	☐
Appendectomy	☐	☐
Tonsillectomy	☐	☐
Hernia Repair	☐	☐
Other surgery (specify):		

HAVE YOU HAD	YES	NO
ADHD	☐	☐
Diabetes	☐	☐
Eating Disorders	☐	☐
Head Injury	☐	☐
Rupture, Hernia	☐	☐
Scarlet Fever	☐	☐
Tuberculosis	☐	☐
OTHER		

PRESENT MEDICATIONS: *(Please include birth control, vitamins and herbal supplements.)*

Drug	Dose	Reason

Do you smoke? ☐ No ☐ Yes If yes, how much ____________

Do you use alcohol? ☐ No ☐ Yes If yes, how much ____________

Do you exercise? ☐ No ☐ Yes If yes, how often/type____________

The above information is true to the best of my ability. I consent to medical treatment at Coastal Carolina University's Student Health Services. Payment for any incurred charges will be the responsibility of the student.

Student signature ____________ Date ____________

(Parent signature required if student is younger than 16 years old.)

Immunization Form (Complete if you were born in 1957 or later.)

Last name ______________________________ First name ______________________________

Social Security number ______________________________ Date of birth ______________________________

Permanent address - PO Box, RFD, Street ____

City ______________________________ State ______________ Zip code ______________

To achieve immunization compliance, students born in 1957 or later must provide Student Health Services with proof of 2 MMRs (Measles, Mumps and Rubella) **OR** 2 Measles (Rubeola), 1 Rubella and 2 Mumps **OR** documentation of physician-diagnosed measles, mumps and laboratory evidence of immunity to rubella. In addition, international students from high risk countries must provide a tuberculin skin test PPD (Mantoux) within the past six months. If there is a history of a positive skin test, a chest X-ray is required. All immunization and tuberculin skin test documents must be submitted in English. You must forward the required information to:

Student Health Services, Coastal Carolina University, P.O. Box 261954, Conway, SC 29528-6054
Telephone number: 843-349-6543 • Fax number: 843-349-6546

Required Immunizations

Measles/Mumps/Rubella (MMR) Dose #1: (Date) ___/___/___ (M D Y) Dose #1: (Date) ___/___/___ (M D Y)
(2 doses required at least 28 days apart)

OR

Rubeola (Measles)(Date) ___/___/___ (M D Y) Reimmunized (Date) ___/___/___ (M D Y) **OR** Titer (Date) ___/___/___ (M D Y) **OR** Illness (Date) ___/___/___ (M D Y)

Rubella (German Measles) (Date) ___/___/___ (M D Y) Reimmunized (Date) ___/___/___ (M D Y)

Mumps (Date) ___/___/___ (M D Y) Reimmunized (Date) ___/___/___ (M D Y) **OR** Titer (Date) ___/___/___ (M D Y) **OR** Illness (Date) ___/___/___ (M D Y)

Required Tuberculosis Screening (if from high risk countries)*

Tuberculin Skin Test (PPD)
(within past 6 months)

Date given: ____ /____ /____ (M D Y) Date read: ____ /____ /____ (M D Y)

Result: ________________ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive ________ negative ________

*Go to http://www.coastal.edu/health/i_requirements.html for list of high risk countries.

Coastal Carolina University *recommends* the following additional immunizations.

▶ **Tetanus-Diphtheria-Pertussis (TDAP)** (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years.)

Dose #1: _____/_____/_____ (M D Y) Dose #2: _____/_____/_____ (M D Y) Dose #3: _____/_____/_____ (M D Y) Dose #4: _____/_____/_____ (M D Y)

Booster: Td or TDaP within the last ten years (Date) _____/_____/_____ (M D Y)

▶ **Tuberculin Skin Test (PPD)** (within past 6 months)

Date given: _____/_____/_____ (M D Y) Date read: _____/_____/_____ (M D Y)

Result: _______________ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive ________ negative ________

▶ **Hepatitis A** (2 Doses)

Dose #1: _____/_____/_____ (M D Y) Dose #2: _____/_____/_____ (M D Y)

▶ **Hepatitis B** (3 Doses)

Dose #1: _____/_____/_____ (M D Y) Dose #2: _____/_____ /_____ (M D Y) Dose #3: _____/_____/_____ (M D Y)

▶ **Varicella (chicken pox)** (immunization or disease) (3 Doses)

History of Disease: ☐ YES ☐ NO
Documented by Medical Provider

Dose #1: _____/_____/_____ (M D Y) Dose #2: _____/_____/_____ (M D Y) Dose #3: _____/_____/_____ (M D Y)

▶ **Meningitis** (Strongly recommended by the American College Health Association)

Dose: _____/_____/_____ (M D Y)

▶ **Quadrivalent Human Papillomavirus (HPV)** (3 Doses)
(Three doses of vaccine for female college students 11-26 years of age at 0, 2 and 6 month intervals.)

Dose #1: _____/_____/_____ (M D Y) Dose #2: _____/_____/_____ (M D Y) Dose #3: _____/_____/_____ (M D Y)

▶ **Influenza (flu)**

Dates: _____/_____/_____ (M D Y) _____/_____/_____ (M D Y) _____/_____/_____ (M D Y) _____/_____/_____ (M D Y)

Medical Provider's Signature or Stamp ____ Date ____________________

REV. 9/06, 9/08