Coastal Carolina University • Student Health Services • Health History Form

Last name (print) _____ First _____ Middle _____

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	☐	☐
Eating Disorders	☐	☐
Anxiety/Depression	☐	☐
ADHD	☐	☐

HAVE YOU HAD	YES	NO
Headaches	☐	☐
Insomnia	☐	☐
Chest Pains	☐	☐
Heart Murmurs	☐	☐
Stomach Troubles	☐	☐
STIs	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Hypertension	☐	☐
Mumps	☐	☐
Recurrent Diarrhea	☐	☐

HAVE YOU HAD	YES	NO
Surgery	☐	☐
Appendectomy	☐	☐
Tonsillectomy	☐	☐
Hernia Repair	☐	☐
Other surgery (specify):		
Diabetes	☐	☐
Head Injury	☐	☐
Rupture, Hernia	☐	☐

HAVE YOU HAD	YES	NO
Scarlet Fever	☐	☐
Tuberculosis	☐	☐
MALES ONLY		
Testicular Mass	☐	☐
Prostate Infection	☐	☐
FEMALES ONLY		
Menstrual problem	☐	☐
Endometriosis	☐	☐
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/Legal guardian signature required if student is under the age of 18.)

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

Last name _____ First name _____ Date of birth _____

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 and a Tetanus (DTap, DTP, DT or Td) vaccination within the last 10 years. Incoming students under 25 years of age living in university housing must provide proof of meningococcal vaccine or a signed waiver/declination. In addition, international students from high risk countries must provide a tuberculin skin test PPD (Mantoux) within the past twelve 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
843-349-6543 • 843-349-6546 fax

Required Immunizations

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

OR

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

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

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

Tetanus-Diphtheria-Pertussis (Primary series with DTaP, DTP, DT, or Td, and booster with Td, and booster with Td or TDap in the last 10 years.)

Dose #1 (Date) ___/___/___ Dose #2 (Date) ___/___/___ Dose #3 (Date) ___/___/___ Dose #4 (Date) ___/___/___
M D Y M D Y M D Y M D Y

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

***Meningococcal Vaccine:** **Menactra** (Date) ___/___/___ **OR** **Menomune** (Date) ___/___/___
M D Y M D Y

*** Proof of vaccination or a signed waiver declining the vaccine is required for incoming students under 25 years of age living in residence halls. If declining this vaccination, a parent/legal guardian's signature is required for students under the age of 18.**

_____ **Declined Meningococcal Vaccination** _____ **Date** _____
(Signature Required)

Printed name _____ Date _____

Parent/Legal Guardian signature _____ Date _____
(Parent/Legal guardian signature required if student is under the age of 18.)

Last name _____ First name _____ Date of birth _____

Required Tuberculosis Screening (International Students from high risk countries)*

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

Tuberculin Skin Test (PPD (within past 12 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 _____

Coastal Carolina University *recommends* the following additional immunizations.

▶**Tuberculin Skin Test (PPD)** (within past 12 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: (Date) _____/_____/_____ (M D Y) Dose #2: (Date) _____/_____/_____ (M D Y) Dose #3: (Date) _____/_____/_____ (M D Y)

▶**Influenza (flu)** Date: _____/_____/_____ (M D Y) Date: _____/_____/_____ (M D Y)

Medical Provider's Signature _____ Date _____
(Physician, Physician Assistant, Nurse Practitioner or Healthcare Facility Stamp)

REV. 2/11