

TO BE COMPLETED BY PATIENT

Check major for which applied:

- NURSING
- TEACHER EDUCATION
- HEALTH SCIENCES

(field) _____

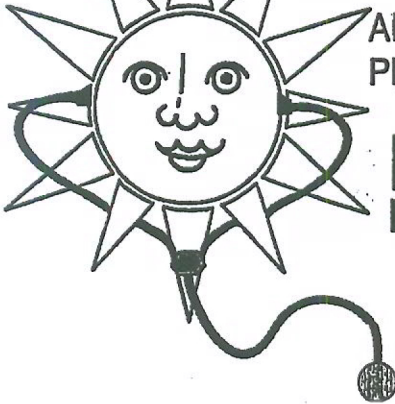


CHICAGO STATE
UNIVERSITY

HEALTH CENTER USE ONLY

Allergies _____

Wellness/Health Center



ADMINISTRATION BUILDING, ROOM 131
PHONE 773 / 995-2010 • FAX 773 / 995-2953

MEDICAL RECORD

All information is strictly confidential

All students recently discharged from the military services may use a copy of their discharge physical if it was completed within 6 months of registration.

PLEASE PRINT ALL INFORMATION

Date of expected entrance _____ ID# _____

Name (Last, First, Middle) _____ Sex M F

Home Address _____ City/State _____ ZIP _____

Phone number _____ Marital status S M D W

Age _____ Birthday: Month ____ Day ____ Year _____ Year In School: Fr So Jr Sr Grad

In case of serious illness, please notify:

Relationship _____ Telephone _____

Are you covered by any type of hospitalization or medical insurance (such as Blue Cross-Blue shield, HMO, Medicaid or Medicare)?

No Yes Name of company _____ Identification number _____

PARENTAL PERMIT: The law requires that parental permission be obtained for medical procedures on minors. The following consent should be signed by the parents or legal guardian so that ordinary medical care may be given without undue delay. However, no procedure will be performed without specific prior consent by parent or guardian.

Consent: "I hereby certify to the best of my knowledge that the preceeding is complete and correct.

_____ do hereby authorize the Chicago State University Wellness/Health Center staff or their consultants to render whatever medical care they deem necessary for the health of (student's name) _____

Date _____ Signed _____ Relationship _____

MEDICAL HISTORY

Name									
Last Name				First Name			Middle Name		
CSU ID NUMBER									
Gender									
<input type="checkbox"/> Male <input type="checkbox"/> Female									
Company									

PLEASE ANSWER ALL QUESTIONS, IF ANY ANSWER IS YES PLEASE DESCRIBE ON LINE BELOW

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
1. Are you allergic to any foods or medications? If so, describe below.			6. Have you ever been advised to have an operation? If so, describe below.		
2. Are you currently taking medications? If so, describe below.			7. Have you ever worked in a hazardous environment such as Asbestos, Lead, Dust, Noise, Chemicals?		
3. Have you had any major injuries or illness? If so, describe below.			8. Do you or have you ever smoked cigarettes? How long? _____ Drink alcohol? How much? _____		
4. Have you been hospitalized or had an operation? If so, describe below.			9. Has any blood relative had: <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Allergies or Asthma <input type="checkbox"/> Mental Illness <input type="checkbox"/> Tuberculosis		
5. Have you ever had an occupational illness or injury? If so, describe below.					

HAVE YOU EVER HAD OR CURRENTLY HAVE:

CHECK EACH ITEM	Y	N	CHECK EACH ITEM	Y	N	CHECK EACH ITEM	Y	N
10. Recent Gain or Lost weight			27. Nose, Throat, Sinus Trouble			44. Varicose Veins		
11. Weakness, Fatigue, Loss of Appetite			28. Voice Change/ Hoarseness			45. Vomiting of Blood		
13. Nervous Condition, Depression			29. Dental/ Gum Disease			46. Frequent Indigestion		
14. Rashes, Allergies, Hives			30. Recurrent Sore Throat			47. Frequent use of Antacids		
15. Skin Disease			31. Chronic/ Recurrent Cough/ Cold			48. Ulcers		
16. Frequent or Severe Headaches			32. Asthma or Wheezing			49. Change of Bowel Habits		
17. Head Injuries			34. Shortness of Breath			50. Frequent Constipation/ Diarrhea		
18. Epilepsy, Fits, Convulsion			35. Tuberculosis			51. Bleeding from Bowels/ Black Stools		
19. Dizziness/ Fainting Spells			36. Heart Trouble/ Medication			52. Hemorrhoids [Piles]/ Rectal Disease		
20. Eye Injury, Infection, Discharge			37. High Blood Pressure			53. Hernia		
21. Double Vision			38. Chest Pain or Pressure			54. Jaundice		
22. Decreased Vision or Blindness			39. Palpitation/ Pounding Heart			55. Diabetes/ High Blood Pressure		
23. Ear Pain, Infection, Discharge			40. Swelling Feet/Ankles			56. Kidney/ Bladder Infection/ Stone		
24. Loss of Hearing			41. Scarlet or Rheumatic Fever			57. Venereal Disease		
25. Broken Bones/ Joint Dislocation			42. Pain Stiffness of Neck/ Back			58. Blood/ Sugar/ Protein in Urine		
26. Arthritis/ Rheumatism / Bursitis			43. Pain in Shoulders/ Arms/ Hands			59. Foot Trouble		

FEMALE PATIENTS COMPLETE AREA BELOW

CHECK EACH ITEM	Y	N	CHECK EACH ITEM	Y	N	CHECK EACH ITEM	Y	N
61. Female Disorder Treatment			64. Duration of Periods			67. Number of Pregnancies		
62. Irregular Menstruation			65. Date of Last Smear			68. Number of Living Children		
63. Painful Menstruation			66. Date of Last Period			69. Are You Pregnant?		

PRIMARY CARE PHYSICIAN

Name _____	Phone _____
Address _____	_____

I hereby certified that to the best of my knowledge, the foregoing answers are complete and correct.

Print Applicant/Student Name _____	Signature of Applicant/Patient _____	Date _____
Print Provider Name _____	Signature of Provider _____	Date _____

GENERAL PHYSICAL EXAM

Date									
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Last Name

Vital Signs						
BP	Pulse	Temp	RR	Weight	Height	BMI

Distance Vision: Uncorrected			Distance Vision: Corrected			Near Vision: Uncorrected			Near Vision: Corrected		
Right	Left		Right	Left		Right	Left		Right	Left	

Clinical Evaluation (√ = Normal ; X = Abnormal ; N= Not examined ; N/A= Does not apply)					
Organ System	Code	Comments	Organ System	Code	Comments
Skin			Hands/ Wrist		
Lymphatics			Hip/ Knee		
Head/ Neck			Ankle/ Feet		
Eyes			Cervical Spine		
Ears			Thoracic Spine		
Nose			Lumbar Spine		
Throat, Mouth, Tongue			Gait		
Teeth			Cranial Nerves		
Chest/ Lungs			Reflexes		
Heart			Babinski		
Murmurs/ Thrills/ Heaves			Romberg		
Breast/ Nipples			Hoffman		
Abdomen/ Liver/Spleen			Motor Strength		
Hernia			Tremors		
Inguinal Nodes			Rectal/ Prostate		
Shoulders			Emotion Status		
Arms/ Elbow			Other		

Labs	Radiology	Cardiology
CBC	Chest X- Ray	EKG
CMP, LIPID, TSH	MRI	2- D Echocardiogram
PSA	CT SCAN	Exercise Stress Test
Vitamin D	Mammogram	
Other	Other	

Option Labs

Urinalysis					
Glucose	Bilirubin	Ketone	S. Gravity	Blood	PH
Protein	Nitrite	Leukocytes		Color	UROB

General Appearance		
Good	Fair	Poor

DIAGNOSIS	PLAN

Physician Signature

Date

IMMUNIZATION HISTORY

			University Identification Number	
Home Address			Preferred Phone ()	Alternate Phone ()
City/State/Country/Zip or Postal Code			E-mail Address	
Date of Birth (mm/dd/yyyy)	Age	Gender M <input type="checkbox"/> F <input type="checkbox"/> Other	Citizenship <input type="checkbox"/> U.S. <input type="checkbox"/> Other (specify)	
Person to Notify in an Emergency Name:		Relationship	Contact Phone ()	
I hereby declare that all statements contained in this record are true and accurate and understand that false or inaccurate information is unlawful and a violation of the student code of conduct.				Alternate Phone ()
Signature:		Date: / /		

+++ This section must be completed by a Licensed Health Care Provider. +++

REQUIRED IMMUNIZATIONS (dates required include month/day/year)

■ **MEASLES-MUMPS-RUBELLA** — 2 doses -Measles, 2 doses-Rubella, and 2 doses-Mumps; (MMR: Exempt if born before 1957)

MMR (strongly recommended) 2 doses; second dose at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1		MEASLES (Rubeola: Hard, Red, or Seven Day) 2 doses; second dose at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1	mm/dd/yy
	2	OR		2	mm/dd/yy
Positive serum titers are also acceptable proof of immunity against measles, mumps and rubella. Lab report required and should be attached.			MUMPS 2 doses; second dose at least 28 days apart AND after 12 months of age	1	mm/dd/yy
				2	mm/dd/yy
Documentation of dates of disease IS NOT acceptable evidence of immunity against measles, mumps or rubella.			RUBELLA (German or 3 day Measles) 2 doses of Rubella All doses must be on or after 1 st birthday; second dose at least 28 days apart.	1	mm/dd/yy
				2	mm/dd/yy

■ **TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DT, DTaP, Td, Tdap)** — All students must show proof of any combination of 3 or more doses of Diphtheria, Tetanus, Pertussis, however only ONE must contain the Pertussis vaccine (Tdap). The last dose of vaccine (Td or Tdap) MUST be within 10 yrs of enrollment date. Tetanus Toxoid (TT) is NOT acceptable.

1 (record first shot here) <input type="checkbox"/> DTP/DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy	2 <input type="checkbox"/> DTP/DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy	3 <input type="checkbox"/> Tdap <input type="checkbox"/> Td mm/dd/yy
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■ **MENINGOCOCCAL CONJUGATE VACCINE** - Meningococcal meningitis is a potentially fatal, vaccine- preventable illness. The Meningococcal Conjugate Vaccine is **REQUIRED** for all students 21 and younger. A second vaccine **MUST** be given if the first vaccine was given before age 16.

Menactra Menveo

1	mm/dd/yy
2	mm/dd/yy

RECOMMENDED IMMUNIZATIONS (complete if received)

HEPATITIS A	1 mm/dd/yy	2 mm/dd/yy	
HEPATITIS B Lab test providing immunity (attach report)	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
HPV (Gardasil) HPV (Cervarix)	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
VARICELLA Lab test providing immunity (attach report)	1 mm/dd/yy	2 mm/dd/yy	Date dx diagnosed and certified by physician mm/dd/yy

TUBERCULOSIS SCREENING

1. Does the student have signs of active tuberculosis disease? Yes No
2. Is the student a member of a high risk group or is student entering the health professions? Yes No
3. Tuberculin Skin Test Date Given / / Date Read / / Results mm Positive ___ Negative ___
4. Chest x-ray(required if tuberculin skin test or IGRA is positive) result normal ___ abnormal ___ Date of x-ray ___/___/___

I. INTERFERON GAMMA RELEASE ASSAY (IGRA)				J. CHEST X-RAY (Required if TST or IGRA is positive)			
Month	Day	Year	(specify method) QFT-G QFT-GIT other _____	Date of chest x- ray			Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
				Month	Day	Year	
Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Intermediate							

K. Influenza

Month	Day	Year		Month	Day	Year
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Required Healthcare Provider Verification and Stamp Required	
HEALTH CARE PROVIDER (MD,DO,APN,NP,PA,RN,LPN,MA,PharmD) VERIFY IMMUNIZATIONS WERE GIVEN	
Provider Name (print)	Signature and credentials
(Address including City/State/Country/Zip or Postal Code)	Date
	Phone

TO SUBMIT FORM to the Wellness/Health Center: Fax to (773) 995-2953 Phone (773) 995-2010
Or Mail to: Chicago State University Wellness/Health Center, 9501 S. King Drive ADM 131, Chicago, IL 60628
Submission Deadlines: Fall – July 1, Spring - December 1, Summer - April 1

COMPLIANCE NOTICE:

If you have not submitted your immunizations for compliance, an (I2) immunization registration hold and a \$25.00 noncompliance fee will be assessed.

The immunization requirements are the following:

- Provide dates of any combination of three or more doses of Diphtheria, Tetanus, and Pertussis containing vaccine. One does must be a Tdap vaccine. The last dose of vaccine (DPT, DTaP, DT, Td, or Tdap) must have been received within 10 years prior to the term of enrollment.
- Show documentation of receipt of 2 doses of live Measles, Mumps, Rubella (MMR) vaccine. Students who cannot provide proof of immunization may provide laboratory (serologic) evidence of measles, mumps, rubella immunity.
- All new admissions under the age of 22, receipt of 1 dose of Meningococcal Conjugate vaccine on or after 16 years of age.
- Resident hall students are required to obtain a **physical** and **tuberculosis screening test within the last 12 months.**
- **INTERNATIONAL STUDENTS: ALL documents must be in ENGLISH or certified translation.** Contact the Chicago State University Wellness and Health Center to schedule your **required** Tuberculosis screening prior to receiving your campus housing assignment.

Contact the Chicago State University Wellness and Health Center for assistance obtaining any needed immunizations or laboratory (serologic) testing. Please call 773 995 2010 for an appointment.

Future registration and matriculation at Chicago State University will be in jeopardy for failure to comply.

Please be sure to make two copies. Bring one copy to the Wellness/Health Center and maintain one copy for your record.