CHICAGO STATE UNIVERSITY

WELLNESS CENTER/ HEALTH CENTER | COOK ADMINISTRATION 131 | Ph: 773.995.2010 | Fax 773.995.2953 | Email: wellness@csu.edu

TO BE COMPLETED BY PATIENT
Check Major for which applied:

- □ NURSING
- □ TEACHER EDUCATION
- □ HEALTH SCIENCES

(Field)_____

HEALTH CENTER USE ONLY

Allergies_____
_____
_____
_____

# MEDICAL RECORD

**ALL INFORMATION IS STRICTLY CONFIDENTIAL**

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

| Date of Expected Entrance | CSU ID Number |
|---|---|
| | |

| Full Name | | |
|---|---|---|
| Last Name | First Name | Middle Name |
| | | |

| Address | | | |
|---|---|---|---|
| Street and Number | City | State | Zip Code |
| | | | |

| Home Phone Number | Cell Phone Number | Date of Birth |
|---|---|---|
| | | |

**Student Email Address** _____@csu.edu

| Marital Status | Student Classification | Age | Sex |
|---|---|---|---|
| ❑ Single ❑ Married ❑ Divorced ❑ Widowed | ❑ Freshman ❑ Sophomore ❑Junior ❑ Senior ❑ Grad | | |

**In case of an illness, please notify:**

| Last Name | First Name | Relationship | Phone Number |
|---|---|---|---|
| | | | |

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

| ❑No ❑Yes | If Yes, what is the name of the 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 procedures will be performed without specific prior consent by parent or guardian.

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

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

Date
_____ _____
Signature Relationship

Updated: May 7, 2014

# MEDICAL HISTORY

| Name | | |
|---|---|---|
| Last Name | First Name | Middle Name |

| CSU ID NUMBER | Gender | Company |
|---|---|---|
| | ❑Male ❑Female | |

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

| CHECK EACH ITEM | YES | NO |
|---|---|---|
| 1. Are you allergic to any foods or medications? If so, describe below. | | |
| 2. Are you currently taking medications? If so, describe below. | | |
| 3. Have you had any major injuries or illness? If so, describe below. | | |
| 4. Have you been hospitalized or had an operation? If so, describe below. | | |
| 5. Have you ever had an occupational illness or injury? If so, describe below. | | |

| CHECK EACH ITEM | YES | NO |
|---|---|---|
| 6. Have you ever been advised to have an operation? If so, describe below. | | |
| 7. Have you ever worked in a hazardous environment such as Asbestos, Lead, Dust, Nolse, Chemicals? | | |
| 8. Do you or have ever smoked cigarettes?<br>How long? _____<br>Drink alcohol?<br>How much? _____ | | |
| 9. Has any blood relative had:<br>❑Cancer ❑ Diabetes ❑ Heart Disease<br>❑ High Blood Pressure ❑ Allergies or Asthma ❑ Mental Illness<br>❑Tuberculosis | | |

**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 Chang/ 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. Hema | | |
| 21. Double Vision | | | 38. Chest Pain or Pressure | | | 54. Jaundice | | |
| 22. Decrease Vision or Blindness | | | 39. Palpitation/ Pounding Heart | | | 55. Diabetes/ High Blood Pressure | | |
| 23. Ear Pain, Infection, Discharge | | | 40.Swelling Feet/Anides | | | 56. Kidney/ Bladder Infection/ Stone | | |
| 24. Loss of Hearing | | | 41. Scarlet or Rheumabic Fever | | | 57. Venereal Disease | | |
| 25. Broken Bones/ Joint Dislocation | | | 42. Pain Stillness of Neck/ Back | | | 58. Blood/ Sugar/ Protein in Urine | | |
| 26. Arthritis/ Rheumatism / Bursitis | | | 43. Pain in Shoulder/ 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 Sear | | | 68. Number of Living Children | | |
| 63. Painful Menstruation | | | 66. Date of Last Period | | | 69. Are You Pregnant? | | |

**PRIMARY CARE PHYSICIAN**

Name _____

Address _____

Phone

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 | | | | | | | | | Last Name |
|---|---|---|---|---|---|---|---|---|---|

| Vital Signs | | | | | | |
|---|---|---|---|---|---|---|
| **BP** | **Pulse** | **Temp** | **RR** | **Weight** | **Height** | **BMI** |
| | | | | | | |

| Distance Vision: Uncorrected | | |
|---|---|---|
| **Right** | **Left** | |
| | | |

| Distance Vision: Corrected | | |
|---|---|---|
| **Right** | **Left** | |
| | | |

| Near Vision: Uncorrected | | |
|---|---|---|
| **Right** | **Left** | |
| | | |

| Near Vision: Corrected | | |
|---|---|---|
| **Right** | **Left** | |
| | | |

| Clinical Evaluation (= Normal ; X = Abnormal ; N= Not exanimated ; 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 | | | Thoriac Spine | | |
| Nose | | | Lumber 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**

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# Student Immunization Record

Student full legal name (exactly as printed on your passport or other government-issued photo identification)

| Last(s) | First name | Middle name |
|---|---|---|
| | | |

Address

| Street and number | City | |
|---|---|---|
| | | |
| State/ Province | Zip/Postal Code | Country |
| | | |

CSU ID Number

Date of Birth: Month / Day / Year

Gender: ❑ Male ❑ Female

Status: ❑ Undergraduate ❑ Graduate ❑ Professional ❑ Part Time ❑ Full Time

**TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.** All information must be in English.

**A. TETANUS-DIPHTHERIA** (Primary series with DTaP or DTP and booster with Td/Tdap in the last ten years meets requirement. Refer to ACIP for details.)

Primary series of four doses with DTaP or DTP: 1 Month Day Year; 2 Month Day Year; 3 Month Day Year; 4 Month Day Year

Tetanus-Diphtheria (Td/Tdap) booster within the last ten years: Month Day Year

**B. M.M.R.** (Measles, Mumps, Rubella) (Two doses required)

1. Dose 1 given at age 12-15 months or later: 1 Month Day Year
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose: 2 Month Day Year

**C. VARICELLA** (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized at the age of 13 or older meets the requirement.)

1. History of Disease ❑Yes ❑ No
2. Varicella Antibody: Month Day Year — Reactive _____ Non-reactive _____
3. Immunization : Dose 1 Month Day Year

Given at least one month after first dose, if age 13 years or older: Dose 2 Month Day Year

**D. HEPATITIS B** (Three doses of a vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody meets the requirement.)

1. Immunization (Hepatitis B)
   1 Month Day Year; 2 Month Day Year; 3 Month Day Year
2. Hepatitis B Surface antibody
   Month Day Year — Result: ❑ Reactive ❑ Non-reactive

**E. HEPATITIS A**

Immunization (Hepatitis A)
1 Month Day Year; 2 Month Day Year

Immunization (Combined Hepatitis A and B Vaccine)
1 Month Day Year; 2 Month Day Year; 3 Month Day Year

**F. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)** (Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)

Immunization (HPV): Dose 1 Month Day Year; Dose 2 Month Day Year; Dose 2 Month Day Year

**G. MENINGOCOCCAL**

1. Tetravalent conjugate (Preferred; data for revaccination pending):
2. Tetravalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5years if increased risk continues):

1 Month Day Year; 2 Month Day Year

**H. 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 the student entering the health profession? ❑ Yes ❑ No
3. Tuberculin Skin Test Date Given Date Read: Month Day Year — Results:
4. Chest x-ray (required if tuberculin skin test is positive) Month Day Year — Result: ❑ Normal ❑ Abnormal

**I. INTERFERON GAMMA RELEASE ASSAY (IGRA)**

Month Day Year

(specify method) QFT-G QFT-GIT other _____

Result: ❑ Negative ❑ Positive ❑ Intermediate

**J. CHEST X-RAY** (Required if TST or IGRA is positive)

Date of chest x- ray: Month Day Year — Result: ❑ Normal ❑ Abnormal

**K. Influenza**

Month Day Year; Month Day Year; Month Day Year

Address

Signature — Phone