

To the Student:
This information is strictly for the use of the Health Center and will not be revealed to anyone without your knowledge and consent.

Gable Health and Counseling Center
13th & Bern Streets, P.O. Box 15234 • Reading, PA 19612-5234
(610) 921-7532 • FAX (610) 921-7590

REPORT OF MEDICAL HISTORY
PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

Sex: M F

Last Name	First Name	Middle	Date of birth	Class Entering	Marital Status
Home Address	City	State	Zip Code	Cell Phone Number	Home Telephone Number
Mother/Guardian: Name	Address	City	State	Zip Code	Cell Phone Number Home Telephone Number
Father/Guardian: Name	Address	City	State	Zip Code	Cell Phone Number Home Telephone Number

Mother/Guardian Employer and Phone Number:

Father/Guardian Employer and Phone Number

Transfer Students: List name and addresses of colleges you have attended.

FAMILY HISTORY

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

Have any of your relatives ever had any of the following?

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

PERSONAL HISTORY (Please answer all questions. Comment on all positive answers in space below or on separate sheet.)

HAVE YOU HAD?	Yes	No
Scarlet Fever		
Measles		
German Measles		
Mumps		
Chicken Pox		
Malaria		
Gum or Tooth trouble		
Sinusitis		
Eye trouble		
Ear, Nose, or Throat trouble		
Surgery		
Appendectomy		
Tonsillectomy		
Hernia Repair		
Other:		

	Yes	No
Insomnia		
Frequent Anxiety		
Worry or Nervousness		
Recurrent Headache		
Recurrent Colds		
Head Injury with unconsciousness		
Hay Fever, Asthma		
Tuberculosis		
Shortness of Breath		
Allergy		
Penicillin		
Sulfonamides		
Serum		
Foods (which)		
Other:		

	Yes	No
Pain/Pressure in Chest		
Chronic Cough		
Palpitations (Heart)		
High or Low Blood Pressure		
Rheumatic Fever or Heart Murmur		
Disease or Injury of Joints		
“Trick” Knee, Shoulder, etc.		
Back Problems		
Tumor, Cancer, Cyst		
Jaundice		
Stomach or Intestinal trouble		

	Yes	No
Gallbladder trouble or Gallstones		
Recurrent Diarrhea		
Rupture, Hernia		
Recent Gain or Loss of Weight		
Dizziness, Fainting		
Weakness, Paralysis		
Venereal Disease		
Albumin/Sugar in Urine		
Frequent Urination		
FEMALES ONLY		
Irregular Periods		
Severe Cramps		
Excessive Flow		

	Yes	No
A. Has your physical activity been restricted during the past five years? (give reasons and durations)		
B. Have you had difficulty with school, studies or teachers? (give details)		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (give details)		
D. Have you had any illness or injury or been hospitalized other than already noted? (give details)		
E. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years? (other than checkups)		
F. Have you been rejected for or discharged from military service because of physical, emotional or other reasons? (if so, give details)		
G. Do you have any questions in regard to your health, family history or other matters, such as pre-marital counseling, which you would like to discuss now with a member of the Health Center?		

USE ADDITIONAL SHEET FOR REMARKS OR ADDITIONAL INFORMATION

I understand that any special physical condition or circumstance that may arise may necessitate the infirmiry personnel to share confidential information with local medical personnel to insure appropriate medical care.

Student's Signature _____

Physician's Signature (acknowledging review) _____

Date _____

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TO THE HEALTH CARE PROVIDER: Please review the student's history and complete the provider's report. Please comment on all positive answers. This student has been accepted. The information supplied will not affect his/her status. It will be used only as a background for providing health and mental health care. This information is strictly for the use of the Gable Health and Counseling Center and is not released without student consent. Physical Exam must be done within 6 months prior to college entrance.

LAST NAME (Print) _____ FIRST NAME _____ MIDDLE _____ SEX: M F

B/ P _____ P _____ Height _____ Weight _____ VISUAL ACUITY: R _____/_____/_____ L _____/_____/_____ Corrected: Y N

Normal Abnormal – Please Describe

	Normal	Abnormal – Please Describe
Skin		
Head and Scalp		
Eyes		
Ears/Hearing		
Mouth, Nose, Throat		
Neck		
Heart		
Lungs		
Abdomen / Hernia		
Genitourinary		
Metabolic/Endocrine		
Musculoskeletal		
Neurologic		
Emotional		

Have you any general comments? _____

Is there loss or seriously impaired function of any paired organ? Yes _____ No _____

Recommendations for physical activity (PE, Intramurals): Please Circle: Unlimited/ Limited Explain: _____

Is the patient now under treatment for any medical or psychological condition? Yes _____ No _____

If yes, please explain: _____

Do you have any recommendations regarding the care of this student, not previously addressed? Yes _____ No _____

If yes, please explain: _____

TUBERCULOSIS SCREENING

Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid.

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____

If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum

2. Is the student a member of a high-risk group or is the student entering the health professions? (Pre-med) Yes _____ No _____

If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

3. Tuberculin Skin Test: Date Given: ____/____/____ Date Read: ____/____/____ 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____

4. Chest x-ray (required if tuberculin skin test is positive) result: normal____ abnormal____ Date of chest x-ray: ____/____/____

Health Care Provider Signature _____ Health Care Provider Name (printed) _____

Address _____

Provider Telephone Number _____ Fax Number _____ Date _____