

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Note: If you answer "YES" to any of the following please explain in the space provided on page 3.

	Y	N
ALLERGIES TO:		
Medication		
Food		
Hay Fever/Environment		
CUTANEOUS (SKIN)		
Acne		
Allergic skin disease		
Eczema/Psoriasis		
Ophthalmic problems (include glasses/contacts)		
RESPIRATORY		
Asthma		
Bronchitis		
Pneumonia		
Ruptured/perforated eardrum		
CARDIOVASCULAR (HEART)		
Heart murmurs (specify if possible)		
Heart pounding/skipping		
High/low blood pressure		
DVT/Phlebitis		
Rheumatic Fever		
Have you ever had your cholesterol checked? Result (if known)		
GASTROINTESTINAL		
Abdominal pain (severe/recurrent)		
Blood in the stool		
Diarrhea (chronic/recurrent)		
Hepatitis		
Hernia		
Irritable Bowel Disease		
Reflux/Ulcer		
Ulcerative colitis/Crohn's Disease		
GENITOURINARY		
Amenorrhea (no periods)		
Blood/protein in urine		
Cystitis (bladder infection)		
Dysmenorrhea (painful periods)		
HPV (genital warts)		
Nephritis or other kidney disease		
Pregnancy		
Polycystic Ovarian Syndrome		
MUSCULOSKELETAL		
Back problems		
Fractures/joint disability		
Severe sprains, ligament injury		
METABOLIC/ENDOCRINE/NUTRITION		
Diabetes		
Thyroid disorder (specify)		
Eating disorder (anorexia, bulimia)		

	Y	N
HEMATOLOGIC		
Anemia		
Mononucleosis		
NEUROLOGIC/PSYCHIATRIC		
Dizzy or fainting spells		
Frequent or severe headaches		
Seizures		
Severe head injury		
Anxiety/Depression		
ADD/ADHD		
Counseling/Psychotherapy		
INFECTIOUS DISEASES		
Tuberculosis		
STD (sexually transmitted disease)		
Rubella (German measles)		
Whooping cough (pertussis)		
PAST MEDICAL HISTORY		
Have you ever been hospitalized or had any operations?		
Do you have any major medical problems?		
Do you take any medications? (include vitamins and birth control pills) Please list in space provided on next page.		
Do you receive allergy shots?		
Is there a family history of any major medical problems (allergies, cancer, diabetes, heart disease, high blood pressure, mental illness, tuberculosis, or hereditary disease)?		

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers				
Sisters				
Children				

PART 3: TO BE COMPLETED AND SIGNED BY A HEALTH CARE PRACTITIONER (or provide equivalent information on separate form).

Syracuse University policy in accordance with New York State public health law requires all students to provide:

- Proof of immunity to measles, mumps, and rubella:
 - Dates of two doses of measles vaccine *after one year of age*, or positive titer results, or physician documentation of disease, and:
 - Date of one dose of rubella vaccine, or positive titer result and;
 - Date of one dose of mumps vaccine, or positive titer result, or physician documentation of disease.

Note: persons born before January 1, 1957 are exempt from the measles, mumps, and rubella requirement.

- Proof of immunity to meningitis or a completed response related to meningococcal meningitis vaccine indicating that the student has either been immunized within the preceding ten years or has opted not to obtain immunization against meningococcal disease.

Please list exact dates (month, day, year) for all applicable immunizations:

REQUIRED

MEASLES/MUMPS/RUBELLA

MENINGITIS

MMR 1st Injection: ___/___/___

MMR 2nd Injection: ___/___/___

Measles 1st injection: ___/___/___

Measles 2nd Injection: ___/___/___

Rubella Injection: ___/___/___

Mumps Injection: ___/___/___

Serologic Evidence Dates:

Measles Titer: ___/___/___

Rubella Titer: ___/___/___

Mumps Titer: ___/___/___

Disease Dates:

Measles: ___/___/___

Mumps: ___/___/___

Result
(+ or -)

Those students wishing to reduce their risk of meningococcal disease should consider receiving the meningitis vaccine. The vaccine is available at S.U. Health Service. Information about the disease and the benefits of the vaccine is available at ... students.syr.edu/health.

I have elected the following option:

_____ Have been immunized within the preceding ten years.

_____ Not to obtain meningitis vaccine (must sign below if waiving vaccine).

Signature of Student:

_____ Date: _____

REQUIRED FOR INTERNATIONAL STUDENTS

TUBERCULOSIS SCREENING

To avoid possible unnecessary procedures and undue financial burden, tuberculosis screening for all international students will be done at S.U. Health Services prior to registration for classes.

PPD placed date: ___/___/___

PPD read date: ___/___/___

PPD result: ___ mm x ___ mm

Chest X-ray date: ___/___/___

Chest X-ray result: _____

OPTIONAL

HEPATITIS B

The American College Health Association, in conjunction with the Advisory Committee on Immunization Practices, recommends that all college students receive the Hepatitis B vaccine series.

Hep B 1st Injection: ___/___/___

Hep B 2nd Injection: ___/___/___

Hep B 3rd Injection: ___/___/___

Tetanus: ___/___/___

Polio completed: ___/___/___

HepA 1st Injection: ___/___/___

HepA 2nd Injection: ___/___/___

Varicella 1st Injection: ___/___/___

Varicella 2nd Injection: ___/___/___

Varicella Titer: ___/___/___

Varicella Disease: ___/___/___

Result _____

I hereby attest to the accuracy of the information given:

HEALTH CARE PRACTITIONER'S SIGNATURE: _____ DATE: _____