

University of Pittsburgh at Bradford

MANDATORY STUDENT HEALTH EVALUATION FORM

PLEASE RETURN COMPLETED FORM TO:

University of Pittsburgh at Bradford
 Student Health Center
 300 Campus Drive
 Bradford, PA 16701-2898
 Phone: (814) 362-5272
 Fax: (814) 362-7514

Page 1

Please Print or Type No Physician's Physical Required for hospital use only

Last Name		First	Middle		Social Security Number
Home Address: Street		City		State	Zip
Phone: Area Code and No.			Student Cell Phone Number		
Age	Birthdate (Month, Day, Year)	Sex	Marital Status	Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INSURANCE INFORMATION:

1. Are you covered by health insurance? () yes () no
 () Coverage through parent or family policy
 () Individual policy holder
2. Please complete the information below or attach photocopy of insurance card (front and back)

NAME OF INSURANCE COMPANY _____

Address of insurance company _____

City _____ State _____ Zip _____ Phone _____

POLICY HOLDER'S NAME _____ Relationship _____

Policy holder's date of birth _____ and Social Security Number _____

Telephone _____ Place of employment _____

POLICY IDENTIFICATION NUMBERS:

Agreement number _____ Group number _____

Plan Code _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Last Name		First	Middle	Relationship	Phone: Area Code & No.
Street Address		City		State	Zip
				Home:	
				Work:	

PERSONAL HEALTH HISTORY

Have you had or do you now have any of the following:

- | NO | YES | NO | YES | NO | YES | | | |
|---------|-----|---------------------------------|---------|-----|----------------------------|---------|-----|---------------------|
| 1. () | () | Vision difficulty, eye problems | 19. () | () | Stroke | 37. () | () | Gout |
| 2. () | () | Ear trouble/hearing difficulty | 20. () | () | Blood clotting disease | 38. () | () | Cancer |
| 3. () | () | Sinus trouble | 21. () | () | Anemia | 39. () | () | Arthritis |
| 4. () | () | Broken nose | 22. () | () | Diabetes | 40. () | () | Broken bones |
| 5. () | () | Repeated tonsil infections | 23. () | () | Digestive disorder | 41. () | () | Sprains |
| 6. () | () | Thyroid problems | 24. () | () | Stomach ulcer | 42. () | () | Dislocations |
| 7. () | () | Abscessed tooth | 25. () | () | Chronic diarrhea | 43. () | () | Concussion |
| 8. () | () | Gum disease | 26. () | () | Ulcerative colitis | 44. () | () | Back problems |
| 9. () | () | Pneumonia | 27. () | () | Liver problem, hepatitis | 45. () | () | Fainting episodes |
| 10. () | () | Eating disorder | 28. () | () | Kidney problem | 46. () | () | Seizure disorder |
| 11. () | () | Asthma | 29. () | () | Bladder infection | 47. () | () | Migraine headaches |
| 12. () | () | Chronic bronchitis | 30. () | () | Pelvic infection | 48. () | () | Nervous disorder |
| 13. () | () | Emphysema | 31. () | () | Disabling menstrual period | 49. () | () | Alcoholism |
| 14. () | () | Heart problems | 32. () | () | Irregular menstrual period | 50. () | () | Drug dependency |
| 15. () | () | Heart murmur | 33. () | () | Hernia | 51. () | () | Depression |
| 16. () | () | Rheumatic heart disease | 34. () | () | Pilonidal sinus/cyst | 52. () | () | Anxiety |
| 17. () | () | Coronary artery disease | 35. () | () | Skin problems | 53. () | () | Eating Disorder |
| 18. () | () | High blood pressure | 36. () | () | Eczema | 54. () | () | Other Psychological |

Do you have ALLERGIES to any of the following:

- | NO | YES |
|--|--|
| 52. () () Medications - Please list name of medications and type of reaction:

_____ | 57. () () Are you currently taking any prescribed medication on a regular or intermittent basis?

Name of medication: _____ Condition for which it is prescribed: _____

_____ |
| 53. () () Inhalants: Circle which ones:
pollen ragweed grasses
dust mold smoke | 58. () () Have you ever been hospitalized for an illness or injury?

Date/Year _____ Reason for hospitalization: _____

_____ |
| 54. () () Food allergies - Please list:

_____ | 59. () () Do you have any chronic health problem which requires regular treatment? |
| 55. () () Chemicals or contact substances:

_____ | 60. () () Do you have a physical handicap or a learning disability with which we can assist you?
(*If yes, contact Disability Resources and Services in the Academic Success Center, 362-7533.) |
| 56. () () Others - Please list:

_____ | |

Please give significant explanations of *all* of the above items to which you have answered YES. Refer to items by number.

IMMUNIZATION REQUIREMENTS

Immunization requirements for all full-time college students born after 1956 are as follows:

Records indicating proof of the immunizations listed below must be submitted with this health form. Attach photocopy of signed or stamped physician or clinic records and/or school immunization certificate listing dates of immunizations.

MANDATORY

Measles/Mumps/Rubella (MMR) (Two doses required)

1. Dose 1 given at age 12-15 months or later.....#1 _____/_____/_____
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose.....#2 _____/_____/_____

NOTE: If you are unable to obtain these records:

One current MMR (Measles, Mumps, and Rubella) vaccine received within the past three years satisfies the immunization requirements. Written proof from the clinic or physician must be attached to this health form.

Additional requirement for students living in campus housing:

MENINGOCOCCAL VACCINE: 1 DOSE

OR A SIGNED WAIVER

COMMUNICABLE DISEASE HISTORY

Please indicate if you have had any of the following diseases and at what age you had the disease.

NO	UNCERTAIN	YES	AGE
()	()	()	_____ Measles (9 days)
()	()	()	_____ German Measles (Rubella 3 days)
()	()	()	_____ Mumps
()	()	()	_____ Chickenpox
()	()	()	_____ Whooping Cough
()	()	()	_____ Diphtheria
()	()	()	_____ Polio
()	()	()	_____ Tuberculosis
()	()	()	_____ Rheumatic Fever
()	()	()	_____ Mononucleosis

FAMILY HEALTH HISTORY

Please indicate if any of your blood relatives (parents, brothers, sisters, children, grandparents) have had any of the following:

NO	YES	RELATIONSHIP
()	()	_____ Diabetes (take Insulin)
()	()	_____ Diabetes (takes pills for it)
()	()	_____ Epilepsy
()	()	_____ High Blood pressure
()	()	_____ Heart Attack
()	()	_____ Heart Disease
()	()	_____ Stroke
()	()	_____ Asthma
()	()	_____ Thyroid problem
()	()	_____ Arthritis
()	()	_____ Gout
()	()	_____ Obesity
()	()	_____ Alcoholism
()	()	_____ Breast cancer
()	()	_____ Other Cancer
()	()	_____ Allergies
()	()	_____ Anxiety, Depression or other mental disorder

SELF EVALUATION OF LIFESTYLE FACTORS

1. EXERCISE: How many times per week do you spend at least 30 minutes in vigorous physical exercise such as biking, running, swimming? _____

2. BODY BASICS: What is your height? _____ Do you consider yourself:
What is your body weight? _____ () underweight () overweight
By how many pounds? _____

Have you ever been told you had high blood pressure? _____ (You can get your blood pressure checked in Health Services room 226 in the Commons Building M-F 8:30am to 5:00pm, Fall & Spring semesters.)

3. NUTRITION: Do you eat a balanced diet, including whole grain breads and cereals, fruits, vegetables, protein and carbohydrates?

Do you try to limit your intake of butter, eggs, fried foods and dairy products which are high in fat and/or cholesterol?

4. TOBACCO USE: Do you smoke cigarettes? _____ Are you interested in quitting? _____
How many per day? _____

How long have you been a smoker? _____

Do you chew tobacco? _____

(Counseling is available in Health Services to quit tobacco.)

5. ALCOHOL USE: How often do you drink alcohol?
() not at all
() less than once a week
() once a week
() 2 or 3 times per week
() more than 3 times per week

What is your average alcohol consumption (number of shots, 8 oz. beers or 6 oz. glasses of wine) per drinking occasion? _____

Do you think you have a problem with alcohol?

(Counseling is available in Counseling Services Rm. 226.)

RELEASE OF INFORMATION

I hereby grant permission to the Student Health Service of the University of Pittsburgh at Bradford to release the information on this Student Health Evaluation Form to Campus Police personnel, Residence Life staff, Counseling Services, Ambulance personnel, and/or Bradford Regional Medical Center Emergency Department personnel if needed, and in the best interest of my health and safety.

Student's Signature

Date

Parent's Signature IF student is under 18 years of age

Date