CLAFLIN UNIVERSITY
Student Health Center
400 Magnolia Street
Orangeburg, South Carolina 29115

Student **Health** Services
Claflin University

HEALTH HISTORY FORM

Please be sure all information is complete.

Date

Name (Last, First, Middle Initial)

Emergency Contact Name

Date of Birth (mm-dd-yyyy)

Relationship Phone #

Email Address Cell Phone #

Have you completed a living will or power of attorney for healthcare?

Claflin ID and/or Last 4 of S SN

ALLERGY HISTORY

List any drug allergies: _____ Reaction: _____

List any allergies to materials (such as latex): _____ Reaction: _____

List any food allergies: _____ Reaction: _____

List any allergies to insects/other: _____ Reaction: _____

Are you receiving allergy injections? _____

CURRENT MEDICATIONS

List any drugs, medications, birth control, vitamins, and dietary supplements you currently use:

_____

_____

PERSONAL HISTORY

Indicate whether you have had any of the following medical issues:

Y	N	General Medical Health Problems
○	○	Acne
○	○	Anemia
○	○	Anxiety
○	○	Asthma/Lung disease
○	○	Bleeding problem
○	○	Blood clots in legs or lungs
○	○	Broken bones
○	○	Cancer
○	○	Cerebral palsy
○	○	Chicken pox
○	○	Colitis, ulcerative/Crohn's disease
○	○	Concussion
○	○	Congenital defect
○	○	Diabetes
○	○	Epilepsy, seizures
○	○	Hearing loss

Y	N	
○	○	Heart murmur/other heart problems
○	○	Hepatitis
○	○	High blood pressure
○	○	High cholesterol
○	○	Irritable bowel
○	○	Kidney infection, stones
○	○	Migraine headaches
○	○	Mononucleosis
○	○	Pneumonia
○	○	Rheumatic fever
○	○	Rheumatoid, other arthritis
○	○	Seasonal allergies
○	○	Scoliosis
○	○	Sickle cell
○	○	Thyroid problems
○	○	Tuberculosis or positive PPD
○	○	Ulcers

Y	N	Men's Health Issues
○	○	Bladder Infection
○	○	Breast mass or enlargement
○	○	Prostate infection
○	○	Steroid use
○	○	Testicular mass or lump

Y	N	Mental Health
○	○	Bipolar disorder
○	○	Depression
○	○	Eating disorder (anorexia, bulimia)
○	○	Substance abuse (alcohol, drugs)

Y	N	Women's Health Issues
○	○	Abnormal Pap Smear
○	○	Bladder infection
○	○	Breast lump or cyst
○	○	Pregnancy

If yes to any of the above, please explain:

_____

_____

_____

CONTINUED ON BACK

SOCIAL HISTORY

TOBACCO
Do you smoke cigarettes?
- O Yes
- O No

If yes, how many packs per day?
# of packs _____

If yes, how many years?
# of years _____

ALCOHOL/DRUG USE
Do you drink alcohol?
- O Yes
- O No

If yes, how many drinks per week?
# of drinks _____

Do you use recreational drugs?
- O Yes
- O No

Have you used needles to inject drugs?
- O Yes
- O No

SEXUAL ACTIVITY
Sexual History:
- O Never sexually active
- O Sexually active in the past but not currently
- O Sexually active

If sexually active, partner(s) are:
Male / Female
Birth control method(s):
_____

Have you had a sexually transmitted infection?
- O Yes
- O No

DIET/EXERCISE
Do you drink coffee/tea/soda daily?
- O Yes
- O No

If yes, how many cups per day?
# of cups _____

Do you drink energy drinks?
- O Yes
- O No

If yes, how many per day?
# of energy drinks _____

How many days per week do you exercise for 30 minutes or more?
0 / 1 - 2/ 3 - 4 / 5+

FAMILY HISTORY
Has any family member in the last two generations (siblings, parents, grandparents) had any of the following?
If yes, who and when?

Y	N	Has a family member had?	Who?
O	O	Alcoholism	_____
O	O	Blood clots in legs, lungs	_____
O	O	Cancer	_____
O	O	Depression	_____
O	O	Diabetes	_____
O	O	Genetic disorder	_____

Y	N	Has a family member had?	Who?
O	O	Heart disease	_____
O	O	High blood pressure	_____
O	O	Liver disease	_____
O	O	Stroke, blood vessel disease	_____
O	O	Suicide	_____
O	O	Other: _____	_____

SURGICAL HISTORY
List all prior operations you have had, with dates (i.e. appendectomy, pinning of fracture):

_____
_____
_____

HOSPITALIZATIONS
List any hospitalizations not included in surgical history (i.e. overnight stay):

_____
_____
_____

ADDITIONAL INFORMATION
Is there anything about your physical, mental or emotional health that would be helpful to Student Health Services in providing you medical care?

_____
_____

READ, CHECK AND SIGN BELOW.

- O I am aware that Student Health Services charges for some services that are not covered under the student health fee. I accept personal responsibility for the payment of incurred charges at the time services are rendered.
- O I understand that I am responsible for filing outpatient charges with my health insurance carrier and acknowledge that my responsibility to the University is unaffected by the existence of health insurance coverage.
- O I authorize any medical treatment for myself that may be advised or recommended by the medical providers at Student Health Services.
- O I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information contained on this form and in my medical records is strictly confidential and will not be released to anymore other than my healthcare provider, without my written authorization unless required by law. If I should be ill or injured or otherwise unable to sign the appropriate medical release form, I give my permission to Student Health Services to release information from my medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.

_____
Signature of patient Date

_____
Signature of legal guardian (if patient is under 18) Date

_____
Signature of reviewing medical provider Date

Student **Health** Services
Claflin University

FOR OFFICE USE ONLY:	
REC'D _____	RX _____
RC _____	_____ MMR
BAN _____	_____ MENI
PNC _____	_____ IGRA
Notified	_____ TBFU
_____	
_____	

Claflin University Immunization Record Form
Complete the following forms and return prior to your assigned orientation date

A. TO BE COMPLETED BY THE STUDENT:

Name _____
Last Name First Name Middle Name

Claflin ID _____ Date of Birth _____/_____/_____ Age when enrolling _____
Month Day Year

Address _____
Street

_____
City State Country Zip Code

Home Phone (___)_____ Cell Phone (___)_____ Email _____

First term of enrollment: ☐ Fall ☐ Spring ☐ Summer

Distance Learner: ☐ Yes ☐ No Term Enrolled _____ (Distance Learner Immunization Exemption is for term of enrollment)

Student Signature _____ Date _____
By signing this document I testify that the content is true and accurate.

PARENTAL CONSENT (for students under age 16):

I hereby authorize Claflin University medical and/or counseling providers to diagnose, treat and/or transfer my son/daughter for treatment, as is appropriate, based on his/her symptoms.

Parent/Guardian Signature (for students under age 16)_____ Date _____

B. REQUIRED IMMUNIZATIONS: SECTIONS B, C, D must be completed and signed by your healthcare provider

1. MMR (Measles, Mumps, Rubella) Two doses required for all students born after 1956

Dose 1 given age 12 months or later ..... _____/_____/_____ **Dose 2 given at least one month after first dose** ..... _____/_____/_____
Month Day Year Month Day Year

EXEMPTION, BORN BEFORE 1957

A positive MMR titer result may be submitted in lieu of vaccination history (attach copy of titer result)

2. MENINGOCOCCAL VACCINE Proof of a conjugate meningococcal vaccine (e.g. Menactra, Menveo) is required of all entering students under age 21. If vaccine was received prior to age 16, a booster is required. A parent/legal guardian's signature is required if students under the age of 18 decline this vaccination.

MENVEO (Date given) _____/_____/_____ age_____ **MENACTRA** (Date given) _____/_____/_____ age_____
Month Day Year Month Day Year

BOOSTER TYPE _____ (Date given) _____/_____/_____

3. TUBERCULOSIS SCREENING: You are REQUIRED to provide proof of TB Skin test screening performed in the United States within the past 12 months, prior to arrival to Claflin University. TB Screening performed outside of the United States will not be accepted.

TUBERCULOSIS SKIN TEST (Date given) _____/_____/_____ (Date read) _____/_____/_____
Month Day Year Month Day Year

_____ **mm reading** ☐ **Negative** ☐ **Positive**

NAME: _____ **Date of Birth:** _____/_____/_____ **Claflin ID:** _____

T-SPOT (IGRA) (Date given) _____/_____/_____ (Result) _____ (attach copy of result)
Month Day Year

***Chest x-ray** (Date given) _____/_____/_____ (Date read) _____/_____/_____ (Result) _____
Month Day Year Month Day Year

*(*Required for positive TB test. Chest X-ray must have been completed within the last three months.)*

C. RECOMMENDED IMMUNIZATIONS:

1. HUMAN PAPILLOMAVIRUS (HPV) Series of three vaccines (either bivalent or quadrivalent) recommended for females age 11-26 years; series of three vaccines (quadrivalent) recommended for males 9-26 years.

HPV Type GARDASIL (HPV 4 quadrivalent) CERVARIX (HPV2 bivalent)
(Date given) _____/_____/_____ (Date given) _____/_____/_____ (Date given) _____/_____/_____
Month Day Year Month Day Year Month Day Year

2. HEPATITIS B Series of three vaccines, or positive titer (attach copy of titer results) **May be combined with Hepatitis A

HEP B (Date given) _____/_____/_____ (Date given) _____/_____/_____ (Date given) _____/_____/_____
Month Day Year Month Day Year Month Day Year

HEP A-B (Date given) _____/_____/_____ (Date given) _____/_____/_____ (Date given) _____/_____/_____
Month Day Year Month Day Year Month Day Year

Positive laboratory/serologic evidence of immunity or prior infection may be substituted (attach copy)

3. HEPATITIS A Series of two vaccines **May be combined with Hepatitis B

HEP A (Date given) _____/_____/_____ (Date given) _____/_____/_____
Month Day Year Month Day Year

4. VARICELLA Series of two doses, given at least one month apart; Documented clinical history of chicken pox; or a positive Varicella titer (attach copy)

VARICELLA (Date given) _____/_____/_____ (Date given) _____/_____/_____ OR Illness_____/_____/_____
Month Day Year Month Day Year Month Day Year

5. Tdap (tetanus, diphtheria and acellular pertussis) Single dose recommended for all students age 64 years or younger

TDAP (Date given) _____/_____/_____
Month Day Year

D. EXEMPTIONS:

This student is exempt from the following immunizations on grounds of permanent medical contraindication OR religious exemption. (attach official documentation)

This student is exempt from the following immunizations until _____/_____/_____, **due to** _____.
(attach official documentation) Month Day Year

E. HEALTHCARE PROVIDER SIGNATURE OR STAMP REQUIRED*

Name: _____ Date: _____/_____/_____
(Please Print) Month Day Year

Address: _____(____)_____
Street/PO Box City State Zip Code Phone

*SIGNATURE _____ Date: _____/_____/_____
(Required of healthcare provider) Month Day Year

After completion of this form, return to:
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