



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

Student **Health** Services  
**Claflyn 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? \_\_\_\_\_

Claflyn 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:

- |                       |                       |  |                       |                       |                                   |                       |                       |                                     |
|-----------------------|-----------------------|--|-----------------------|-----------------------|-----------------------------------|-----------------------|-----------------------|-------------------------------------|
| <b>Y</b>              | <b>N</b>              | <b>General Medical Health Problem:</b> | <b>Y</b>              | <b>N</b>              | Heart murmur/other heart problems | <b>Y</b>              | <b>N</b>              | <b>Men's Health Issues</b>          |
| <input type="radio"/> | <input type="radio"/> | Acne                                   | <input type="radio"/> | <input type="radio"/> | Hepatitis                         | <input type="radio"/> | <input type="radio"/> | Bladder Infection                   |
| <input type="radio"/> | <input type="radio"/> | Anemia                                 | <input type="radio"/> | <input type="radio"/> | High blood pressure               | <input type="radio"/> | <input type="radio"/> | Breast mass or enlargement          |
| <input type="radio"/> | <input type="radio"/> | Anxiety                                | <input type="radio"/> | <input type="radio"/> | High cholesterol                  | <input type="radio"/> | <input type="radio"/> | Prostate infection                  |
| <input type="radio"/> | <input type="radio"/> | Asthma/Lung disease                    | <input type="radio"/> | <input type="radio"/> | Irritable bowel                   | <input type="radio"/> | <input type="radio"/> | Steroid use                         |
| <input type="radio"/> | <input type="radio"/> | Bleeding problem                       | <input type="radio"/> | <input type="radio"/> | Kidney infection, stones          | <input type="radio"/> | <input type="radio"/> | Testicular mass or lump             |
| <input type="radio"/> | <input type="radio"/> | Blood clots in legs or lungs           | <input type="radio"/> | <input type="radio"/> | Migraine headaches                | <b>Y</b>              | <b>N</b>              | <b>Mental Health</b>                |
| <input type="radio"/> | <input type="radio"/> | Broken bones                           | <input type="radio"/> | <input type="radio"/> | Mononucleosis                     | <input type="radio"/> | <input type="radio"/> | Bipolar disorder                    |
| <input type="radio"/> | <input type="radio"/> | Cancer                                 | <input type="radio"/> | <input type="radio"/> | Pneumonia                         | <input type="radio"/> | <input type="radio"/> | Depression                          |
| <input type="radio"/> | <input type="radio"/> | Cerebral palsy                         | <input type="radio"/> | <input type="radio"/> | Rheumatic fever                   | <input type="radio"/> | <input type="radio"/> | Eating disorder (anorexia, bulimia) |
| <input type="radio"/> | <input type="radio"/> | Chicken pox                            | <input type="radio"/> | <input type="radio"/> | Rheumatoid, other arthritis       | <input type="radio"/> | <input type="radio"/> | Substance abuse (alcohol, drugs)    |
| <input type="radio"/> | <input type="radio"/> | Colitis, ulcerative/Crohn's disease    | <input type="radio"/> | <input type="radio"/> | Seasonal allergies                | <b>Y</b>              | <b>N</b>              | <b>Women's Health Issues</b>        |
| <input type="radio"/> | <input type="radio"/> | Concussion                             | <input type="radio"/> | <input type="radio"/> | Scoliosis                         | <input type="radio"/> | <input type="radio"/> | Abnormal Pap Smear                  |
| <input type="radio"/> | <input type="radio"/> | Congenital defect                      | <input type="radio"/> | <input type="radio"/> | Sickle cell                       | <input type="radio"/> | <input type="radio"/> | Bladder infection                   |
| <input type="radio"/> | <input type="radio"/> | Diabetes                               | <input type="radio"/> | <input type="radio"/> | Thyroid problems                  | <input type="radio"/> | <input type="radio"/> | Breast lump or cyst                 |
| <input type="radio"/> | <input type="radio"/> | Epilepsy, seizures                     | <input type="radio"/> | <input type="radio"/> | Tuberculosis or positive PPD      | <input type="radio"/> | <input type="radio"/> | Pregnancy                           |
| <input type="radio"/> | <input type="radio"/> | Hearing loss                           | <input type="radio"/> | <input type="radio"/> | Ulcers                            |                       |                       |                                     |

If yes to any of the above, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

**CONTINUED ON BACK**

# SOCIAL HISTORY

**TOBACCO**  
Do you smoke cigarettes?  
 Yes  
 No

If yes, how many packs per day?  
# of packs \_\_\_\_\_

If yes, how many years?  
# of years \_\_\_\_\_

**ALCOHOL/DRUG USE**  
Do you drink alcohol?  
 Yes  
 No

If yes, how many drinks per week?  
# of drinks \_\_\_\_\_

Do you use recreational drugs?  
 Yes  
 No

Have you used needles to inject drugs?  
 Yes  
 No

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

If sexually active, partner(s) are:  
Male / Female \_\_\_\_\_

Birth control method(s):  
\_\_\_\_\_

Have you had a sexually transmitted infection?  
 Yes  
 No

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

If yes, how many cups per day?  
# of cups \_\_\_\_\_

Do you drink energy drinks?  
 Yes  
 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?
<input type="radio"/>	<input type="radio"/>	Alcoholism	_____
<input type="radio"/>	<input type="radio"/>	Blood clots in legs, lungs	_____
<input type="radio"/>	<input type="radio"/>	Cancer	_____
<input type="radio"/>	<input type="radio"/>	Depression	_____
<input type="radio"/>	<input type="radio"/>	Diabetes	_____
<input type="radio"/>	<input type="radio"/>	Genetic disorder	_____

Y	N	Has a family member had?	Who?
<input type="radio"/>	<input type="radio"/>	Heart disease	_____
<input type="radio"/>	<input type="radio"/>	High blood pressure	_____
<input type="radio"/>	<input type="radio"/>	Liver disease	_____
<input type="radio"/>	<input type="radio"/>	Stroke, blood vessel disease	_____
<input type="radio"/>	<input type="radio"/>	Suicide	_____
<input type="radio"/>	<input type="radio"/>	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.

- 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.
- 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.
- I authorize any medical treatment for myself that may be advised or recommended by the medical providers at Student Health Services.
- 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 anyone 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 PAPILOMAVIRUS (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:  
Student Health Center, 400 Magnolia Street, Orangeburg, SC 29115**

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**Clafin University**  
400 Magnolia Street  
Orangeburg, SC 29115