

Personal Health History

1. **REQUIRED IMMUNIZATIONS – MUST BE COMPLETED.**

If born after 1957:

TWO MMR injections that have been given after the first birthday, at least one month apart.

(1st) Month/day/year : _____/_____/_____ (2nd) Month/day/year : _____/_____/_____

OR attach a laboratory copy showing immune **Rubeola, Rubella and Mumps IgG titers.**

Signature and office stamp of physician or immunizing official **OR** you may attach an **official copy** of immunization record.

2. **REQUIRED FOR INTERNATIONAL STUDENTS**

ONLY: QuantiFERON Gold TB test completed in the United States in the past year. Please attach copy of lab results.

3. **Other Immunizations**

List dates of injection by: M/D/Y

1. Rubeola: _____

2. Mumps: _____

3. Rubella: _____

4. Tetanus (Td): _____ Tdap: _____

5. Polio: _____

6. Hepatitis B: 1. _____ 2. _____

3. _____

7. HPV: 1. _____ 2. _____

3. _____

8. Chicken Pox (Varicella): _____

9. Other: _____

*4. **Meningitis–Menomune or Menactra:**

5. **I HAVE THIS “MED-ALERT” CONDITION:**

6. **Allergies**

Please check those to which you are allergic.

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | |
| <input type="checkbox"/> Any other drug _____ | |
| <input type="checkbox"/> Environmental _____ | |
| <input type="checkbox"/> Insects _____ | |
| <input type="checkbox"/> Food _____ | |

7. **Acute Infectious Diseases**

Please check those you have experienced.

- NONE
- Chicken Pox
- Diphtheria
- Infectious mononucleosis
- Hepatitis (Specify type) _____
- Measles (Rubeola)
- Measles (Rubella)
- Mumps
- Pneumonia
- Rheumatic fever
- Scarlet fever
- Tonsillitis
- Other _____

8. **Chronic Diseases/Conditions**

Please check those you have experienced.

- NONE
- ADD/ADHD
- Anemia
- Arthritis
- Asthma
- Anxiety (Depression)
- Bleeding trait
- Cancer or malignancy
- Chronic bronchitis
- Chronic skin disease
- Concussion/head injury
- Convulsions or seizures (epilepsy)
- Diabetes
- Diseases of the colon
- Eating disorder
- Faint easily
- Gallbladder/liver disease
- Hay fever
- Headaches (recurrent)
- Hearing problem
- Heart disease
- Heart murmur
- High blood pressure
- Kidney disease
- Malaria
- Orthopedic problem (i.e., knee, back)
- Sinus infection (chronic)
- Sleep disorder
- Speech _____
- Thyroid or endocrine disturbance
- Tuberculosis
- Ulcer (stomach or duodenal)
- Visual _____
- Other _____

9. **Female Menstrual History**

Please check those that apply.

- Cramps
- Excessive flow
- Irregularity
- Do you miss classes because of menses?
- Have you received treatment for menstrual disorder?

10. **Medication**

NONE

List medications prescribed by physician.

Other medication _____

* Please refer to our web site, <http://depts.loras.edu/StudentDevelopment/health/meningitis.html>, for more information about meningitis. We highly recommend that you are immunized for meningitis.

11. I have received meningitis materials on the web site or requested by mail: _____

Signature of Student