COPPIN
STATE UNIVERSITY
EST. 1900

HELENE FULD SCHOOL OF NURSING

Community Health Center

2601 W. North Avenue, Suite 131, Baltimore, MD 21216
Phone: 410-951-4188 Fax: 410-951-6158 eFax: 410-779-9295

Confidential
Health History

PLEASE PRINT OR TYPE: **STUDENT ID#** _____

I plan to participate in Intercollegiate Sports. Yes❑ No❑

_____
Last Name First Name Middle

_____
Soc. Sec# Sex: Male ❑ Female ❑

_____
Home Address City or Town

_____
Home Telephone Work Telephone

S❑ M ❑ D ❑W ❑
Marital Status Month & Year Entering Coppin Date of Birth

_____
Emergency Contact Name Phone Number

Health Insurance Information: (The University requires all full time students to have health insurance. You may purchase a policy through the University)
If you have any type of health insurance or HMO specify details.

_____
Company or Organization Name

_____
Address

_____
Member or Group Number Expiration Date

Medical History - please indicate problems you have now or may have had in the past.

Weight: _____
Height: _____

Please Circle One

Acne	Yes	No	Dyslexia	Yea	No	Hypoglycemia (Low sugar)	Yes	No
Alcohol problem	Yes	No	Ear Problem	Yes	No	Infectious Mono	Yes	No
Allergies	Yea	No	Pneumonia	Yes	No	Joint Disease	Yes	No
Sickle Cell	Yes	No	Specify_____			Kidney Problems	Yes	No
Asthma	Yes	No	Eczema	Yes	No	Knee Injury	Yes	No
Back problems	Yes	No	Emotional Illness	Yes	No	Migraines	Yes	No
Bladder Infections	Yes	No	Gallbladder Problems	Yes	No	Nervous Stomach	Yes	No
Bleeding Problems	Yes	No	Gonorrhea	Yes	No	Urethritis (Non-gonococcal)	Yes	No
Broken Bones	Yes	No	Gout	Yes	No	Obesity	Yes	No
Breast Disease	Yes	No	Hay Fever	Yes	No	Peptic Ulcer (Gastric or duodenal)	Yes	No
Bronchitis	Yes	No	Hearing Loss	Yes	No	Rheumatic Fever	Yes	No
Cancer	Yes	No	Heart Problems:	Yes	No	Seizures	Yes	No
Colitis	Yes	No	Chest Pain	Yes	No	Sinus Problem	Yes	No
Concussion	Yes	No	Murmurs	Yes	No	Suicide Attempt	Yes	No
Condyloma (Genital warts)	Yes	No	Rheumatic Disease	Yes	No	Syphilis	Yes	No
Depression	Yes	No	Other _____			Sexually Transmitted Disease	Yes	No
Diabetes	Yes	No	Shortness of Breath	Yes	No			
Diarrhea	Yes	No	Hernia	Yes	No			
Dizziness	Yes	No	Herpes (Genital)	Yes	No			
Drug Dependency	Yes	No	High Blood Pressure	Yes	No			

MALES

Prostate Problems	Yes	No
Lump in Testicles	Yes	No

FEMALES

Irregular Periods	Yes	No
Severe Cramps	Yes	No
Pregnancy	Yes	No
Cystic Breasts	Yes	No

1. Surgery: i.e. Appendectomy, tonsillectomy, hernia repair, etc. (List below).

2. List below all drugs, including over the counter, birth control, laxatives, and sleeping medication currently being used:

3. List below all allergies to medicine, food, insect stings, or other:

4. List any disabilities which require assistance:

FAMILY HISTORY

MOTHER'S NAME (please print)	Age	FATHER'S NAME	Age
Good ❑ Fair ❑ Poor ❑ HEALTH STATUS		Good ❑ Fair ❑ Poor ❑ HEALTH STATUS	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	

Number of siblings: Brothers_____ Sisters_____

Have *any* of your blood relatives ever had any of the following? If you do not know, discuss with a relative.

	Relationship		Relationship
Arthritis	Yes No	Hay Fever	Yes No
Asthma	Yes No	Heart Attack	Yes No
Alcoholism/.Addiction	Yes No	High Cholesterol	Yes No
Blood Pressure	Yes No	Hyperlipidemia	Yes No
Bleedin[g] Disorder	Yes No	Kidney Disease	Yes No
Cancer	Yes No	Stroke	Yes No
Convulsions	Yes No	Suicide	Yes No
Diabetes	Yes No	Stomach Disease	Yes No
Epilepsy	Yes No	Tuberculosis	Yes No

Do you have any questions or concerns in regard to health, family history, or family matters, which you need to discuss with a member of the health center? If yes please explain. Yes ❑ No ❑

_____

_____

_____

_____

_____

This form has been completed truthfully to the best of my ability.

Student Signature: _____ Date: _____

Parental Permit:

The law requires that parental permission be obtained for minors. The consent form should be signed by parents so that procedures of emergency precautions may be carried out promptly with no unnecessary delays. No procedures will be performed, except in extreme emergency, without parents being contacted and fully informed.
I give permission for diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter and also to present information concerning his/her medical condition to other responsible College Officials when deemed desirable.

Signed: _____

PHYSICAL EXAMINATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physical exam. This student has been accepted. The information supplied will be used only as a background for providing healthcare. The information is strictly for the use of the Health Services and will not be released without student consent. Please mail immediately.

Height	Weight		Endocrine	Skin
Eyes	Vision (R) (L)		Correction (R) (L)	
Ears		Drums (R) (L)		Hearing (R) (L)
Nose		Septum		Sinuses
Oropharynx		Tonsils		Teeth
Neck		Cervical Glands		Thyroid
Chest		Breasts		Lungs
Heart	Rate	Rhythm	Murmurs	Blood Pressure
Abdomen	Liver	Spleen	Kidney	Hernia
Skeletal	Spine	Joints	Feet	
Neuro		Reflexes		Emotional

Laboratory Urinalysis

Sugar_____ Protein _____ Hematuria _____ SG

Optional HCT_____ Choi _____

IMMUNIZATION HISTORY

NOTE: Vaccines and or titers are not applicable for H.I.M. Students. If born BEFORE 1957, you are considered immune to M-M-R (measles, mumps, and rubella). If born AFTER 1957, you should have a re-vaccination for MMR before admission. **Titers are required for MMR, Varicella and Hepatitis B; by clinical agencies for nursing students.**

IMMUNIZATION DATES

1. MMR:	FIRST SHOT	SECOND SHOT	**To be valid, *2nd shot* must be *after 1980.***
Measles	_____	_____	*(Titers must be accompanied for nursing students)*
Mumps	_____	_____	*(Preferred but not required for H.I.M. Students)*
(Rubeola)			
Rubella	_____	_____	
(German Measles)			

2. DTP: (Diphtheria, Tetanus, Pertussis) *(Preferred but not required for H.I.M. Students)*

_____ *(Childhood Series)*

TD Booster _____ *required within past 10 years.*

3. TB Test or Chest X-Ray: ***If PPD is positive, Chest X-ray is required. Please attach a copy of X-ray report.***

Date Placed: _____ Date Read: _____ Result: _____

4. Polio (*Childhood Series/Booster or Titers are expectable*):

_____ *(Required for nursing student. Preferred but not required for H.I.M. Students)*

5. .Hepatitis B: *(Titers must be accompanied for nursing students if series is complete.)*

_____ *(Preferred but not required for H.I.M. Students.)*

1st *2nd* ***Final***

6. Varicella: _____ *(Titers must be accompanied for nursing students. Preferred but not required for H.I.M. Students)*

7.Meningitis:_____

_____ **Date:** _____

Physician Signature and Physician Stamp

Affix Stamp Here: