A complete Health History Form must be received prior to entry documenting that all medical history, physical, and immunization requirements have been met. Failure to complete this form and comply with immunization requirements by the first day of classes will result in a late fee. Failure to complete all requirements by the 30th day of classes may result in withdrawal.

### PART ONE: STUDENT IDENTIFICATION – to be completed by student

<table>
<thead>
<tr>
<th>NAME - LAST</th>
<th>FIRST</th>
<th>MI</th>
<th>UR STUDENT ID#</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE OF BIRTH (mo/day/yr)</td>
<td>COUNTRY OF RESIDENCE WITHIN PAST 5 YEARS</td>
<td>GENDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HOME ADDRESS

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>(AREA CODE) PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell:</td>
<td></td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

SCHOOL OR COLLEGE REGISTRATION INFORMATION

- School of Medicine & Dentistry (MD students)  Expected year of graduation: ________
- Eastman Institute of Oral Health

- School of Nursing
  - Accelerated Nursing Program
  - RN Matriculated
  - Masters

- Post Masters Certificate Program
- PhD
- DNP

ENTERING SEMESTER

- Fall
- Spring
- Summer
- 2016
- 2017
- 2018
- 2019

STUDENT STATUS

- Part-time*  *Note: Part-time students are required to submit a $35 processing fee with this form. Enclose a personal check payable to UHS or your term bill will be charged directly.

- Previous UR student: Yes
- Previous UR Employee/Volunteer: Yes

### PART TWO: PERSONAL HEALTH HISTORY

- This information is strictly for the use of the University of Rochester and will not be released to anyone without your knowledge and written consent.

Do you take daily medication?  Yes  No
Do you have any medication/substance allergies?  Yes  No

*If yes to the above questions, please complete the Allergy & Medication List on the enclosed separate sheet.

Latex allergy?  Yes  No  Describe: 
Take allergy desensitization injections?  Yes  No  If yes, do you plan to receive your allergy injections at UHS?  Yes  No
MEDICAL OR HEALTH CONCERNS – Please mark any conditions/diseases you have had.

<table>
<thead>
<tr>
<th>Mark</th>
<th>Condition/Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>ADD/ADHD</td>
</tr>
<tr>
<td>☐</td>
<td>Anemia</td>
</tr>
<tr>
<td>☐</td>
<td>Asthma</td>
</tr>
<tr>
<td>☐</td>
<td>Arthritis</td>
</tr>
<tr>
<td>☐</td>
<td>Anxiety or nervousness</td>
</tr>
<tr>
<td>☐</td>
<td>Bleeding disorder</td>
</tr>
<tr>
<td>☐</td>
<td>Blood disorder</td>
</tr>
<tr>
<td>☐</td>
<td>Cancer/malignancy</td>
</tr>
<tr>
<td>☐</td>
<td>Cerebral palsy</td>
</tr>
<tr>
<td>☐</td>
<td>Chicken pox</td>
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<tr>
<td>☐</td>
<td>Cystic Fibrosis</td>
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<tr>
<td>☐</td>
<td>Depression</td>
</tr>
<tr>
<td>☐</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>☐</td>
<td>Digestive troubles</td>
</tr>
<tr>
<td>☐</td>
<td>Dizziness/fainting</td>
</tr>
<tr>
<td>☐</td>
<td>Eating disorder: anorexia nervosa, bulimia</td>
</tr>
<tr>
<td>☐</td>
<td>Hay fever/seasonal allergies</td>
</tr>
<tr>
<td>☐</td>
<td>Heart disease</td>
</tr>
<tr>
<td>☐</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>☐</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>☐</td>
<td>High cholesterol</td>
</tr>
<tr>
<td>☐</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>☐</td>
<td>Inflammatory bowel disease/ Crohn's, ulcerative colitis</td>
</tr>
<tr>
<td>☐</td>
<td>Insomnia</td>
</tr>
<tr>
<td>☐</td>
<td>Kidney problems</td>
</tr>
<tr>
<td>☐</td>
<td>Menstrual problems</td>
</tr>
<tr>
<td>☐</td>
<td>Migraine/recurrent headache</td>
</tr>
<tr>
<td>☐</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>☐</td>
<td>Obesity</td>
</tr>
<tr>
<td>☐</td>
<td>Pain, chronic</td>
</tr>
<tr>
<td>☐</td>
<td>Peptic ulcer / GERD</td>
</tr>
<tr>
<td>☐</td>
<td>Pelvic infection</td>
</tr>
<tr>
<td>☐</td>
<td>Phlebitis/blood clot</td>
</tr>
<tr>
<td>☐</td>
<td>Polio</td>
</tr>
<tr>
<td>☐</td>
<td>Prostatitis</td>
</tr>
<tr>
<td>☐</td>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>☐</td>
<td>Seizure disorder (epilepsy)</td>
</tr>
<tr>
<td>☐</td>
<td>Sexually transmitted infections</td>
</tr>
<tr>
<td>☐</td>
<td>Skin disorder</td>
</tr>
</tbody>
</table>

Do you have an illness, chronic condition or medical problem for which you are currently being treated? ☐ Yes ☐ No
Describe: ________________________________________________________________

If yes, please specify and have your physician write a medical summary and enclose with this form. (Full time students)

Have you had any hospitalizations or surgeries? ☐ Yes ☐ No
If yes, list date(s) and reason(s) ____________________________________________

Do you regularly exercise, 3 or more times per week? ☐ Yes ☐ No

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If Yes, how much? ________________________________

Do you drink alcohol? ☐ Yes ☐ No If Yes, how much and how often ________________________________

Have you used any drugs such as marijuana, cocaine, heroin or crack within the last year? ☐ Yes ☐ No
If Yes, describe: ____________________________________________________________

Have you had any treatment for drug or alcohol abuse? ☐ Yes ☐ No
If yes, describe (including year): ______________________________________________

Do you have any health impairments (including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior) that would pose a potential risk to patients or personnel, or which might interfere with the performance of your responsibilities? ☐ Yes ☐ No
If yes, explain: __________________________________________________________________________

PART THREE: FAMILY MEDICAL HISTORY

Mark all the diseases that apply to your family:
☐ Heart disease ☐ Hypertension ☐ Diabetes ☐ Cancer
☐ Emotional / mental illness ☐ Alcohol/drug addiction ☐ Stroke ☐ Other (please specify):

PART FOUR: CERTIFICATION

I certify that the information submitted on this form is accurate to the best of my knowledge. I certify that I have received the HIPAA Notice of Privacy Practices. I will contact University Health Service if I have any further questions about these issues.

STUDENT NAME (please print):________________________________________________________DATE:_________________

STUDENT SIGNATURE:__________________________________________________________________________
## PART FIVE: THE REQUIREMENTS BELOW NEED HEALTH CARE PROVIDER VERIFICATION:

### FEDERAL, NEW YORK STATE & UNIVERSITY REQUIREMENTS

#### MEASLES (RUBEOLA)
- 2 doses of live vaccine given on or after the first birthday: must be given at least 28 days apart with the second dose after age 15 months
- OR serologic test showing positive titer (lab report must be included)

#### MUMPS
- 2 doses of live vaccine given on or after the first birthday: must be given at least 28 days apart with the second dose after age 15 months
- OR serologic test showing positive titer (lab report must be included)

#### RUBELLA
- 1 dose of live vaccine given on or after the first birthday
- OR serologic test showing positive titer (lab report must be included)

### TUBERCULIN SKIN TEST (MANTOUX) REQUIREMENTS

Two TST’s (Mantoux intradermal skin tests) - The 1st is due within one year of the start date of the program and the 2nd is due within 3 months of that start date. If positive TST or history of past positive TST is reported, a chest x-ray must be obtained after positive TST and a copy of the chest x-ray report attached. **Example:**

- **Start Date:** (9/1/12)
- **1st TST:** (9/1/11 to 8/1/12)
- **2nd TST:** (6/1/12 to 8/31/12)

#### TETANUS- DIPHTHERIA or Tdap
- Td
- Tdap

#### POLIO VACCINE
- IPV
- OPV

### Documentation

**MMR Documentation**
- 1st Immunization: ___________ mm/dd/yy
- AND
- 2nd Immunization: ___________ mm/dd/yy
- MAY SUBSTITUTE MMR.

**Measles Documentation**
- 1st Immunization: ___________ mm/dd/yy
- AND
- 2nd Immunization: ___________ mm/dd/yy
- OR Serologic Test: ___________ mm/dd/yy
- Result
  - positive
  - indeterminate
  - negative

**Mumps Documentation**
- 1st Immunization: ___________ mm/dd/yy
- AND
- 2nd Immunization: ___________ mm/dd/yy
- OR Serologic Test: ___________ mm/dd/yy
- Result
  - positive
  - indeterminate
  - negative

**Rubella Documentation**
- Immunization: ___________ mm/dd/yy
- OR Serologic Test: ___________ mm/dd/yy
- Result
  - positive
  - indeterminate
  - negative

**TETANUS- DIPHTHERIA or Tdap**
- Immunization: ___________ mm/dd/yy
- Td  Tdap

**Tetanus-Diphtheria** (every 10 years)

**OR**

Tdap: The CDC recommends that health providers who have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received it. **Reference:** 12/06

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5517a2.htm

**POLIO VACCINE**
- Immunization: ___________ mm/dd/yy (date of completion)
IMMUNIZATIONS AND TESTS: INFORMATION IS REQUIRED

Hepatitis B vaccine: The CDC STRONGLY RECOMMENDS hepatitis B vaccination (includes 3 doses of vaccine and post-vaccine titer 1-2 months after 3rd dose) for all health care professionals. A signed declination form must be completed if this applicant declines vaccine.

Varicella Status: Documentation of 2 doses of varicella vaccine or a varicella titer result must be provided. UHS strongly recommends vaccination for any students who have a negative varicella titer.

Meningococcus Vaccine: Review enclosed information

HEPATITIS B

Immunization #1 mm/dd/yy
Immunization #2 mm/dd/yy
Immunization #3 mm/dd/yy
Serologic Test: Result: 
(if available) mm/dd/yy (include copy of lab report if available)

☐ DECLINATION: I decline the hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. I understand the risks of being susceptible to infections and blood borne diseases and decline immunization at this time. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Student: ___________________________ Date ________________

MENINGOCOCCUS

Immunization #1 mm/dd/yy
Immunization #2 mm/dd/yy

☐ DECLINATION: I certify that I have received the information about the risks, benefits, availability and alternatives to meningococcus vaccination. I understand the information and I decline the meningococcus vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring meningitis. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Student: ___________________________ Date ________________

VARICELLA (CHICKEN POX)

Serologic Test: Result: mm/dd/yy (lab report must be included)
OR
Immunization #1 mm/dd/yy
Immunization #2 mm/dd/yy

Optional:

HUMAN PAPILLOMA VIRUS VACCINE (HPV):

Immunization #1 mm/dd/yy
Immunization #2 mm/dd/yy
Immunization #3 mm/dd/yy

PART SIX: TO BE COMPLETED IN INK BY HEALTH CARE PRACTITIONER.

Physical exam form provided to be submitted with this form.

I have reviewed all of the above information including immunization dates and it is correct to the best of my knowledge.

Practitioner’s Name (please print): _____________________________________________
Practitioner’s Signature: ____________________________________
Address: _________________________________________________________________
City State Zip Code Country
Work Telephone ( ) __________________________ Date of completion of form __/__/____

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