

COPPIN STATE UNIVERSITY
DIVISION OF STUDENT LIFE
HEALTH PROMOTION / WELLNES CENTER

Confidential

Health History must be completed.
This is mandatory for all students

PLEASE PRINT OR TYPE

I plan t participate in Intercollegiate Sports: Yes ___ No ___

Last Name	First Name	Middle
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Social Security #	Sex:	M	F	
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Home Address	City or Town	State	Zip
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Home Telephone	Work Telephone
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Marital Status	Month & Year Entering Coppin	Date of Birth
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Next of Kin's Name and Address (relationship)	Phone Number
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Next of Kin's Business Address	Business Number
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Health Insurance Information
If you have any type of health or HMO specify details.

Company or Organization

Address

Policy or Contract Number

Expiration Date

It is required that all full-time students have health insurance (a policy is available through the University)

Past History - Please indicate problems you have now or may have had in the past...

Weight _____

Height _____

Please Circle One

Acne	Yes	No	Dyslexia	Yes	No	Hypoglycemia	Yes	No
Alcohol	Yes	No	Ear Problem	Yes	No	(Low Sugar)		
Allergies	Yes	No	Pneumonia	Yes	No	Infectious Mono	Yes	No
Sickle Cell	Yes	No	Specify _____			Joint Disease	Yes	No
Asthma	Yes	No	Eczema	Yes	No	Kidney Problems	Yes	No
Back Problems	Yes	No	Emotional illness	Yes	No	Knee Injury	Yes	No
Bladder Infections	Yes	No	Gallbladder Problems	Yes	No	Migraines	Yes	No
Bleeding Trait	Yes	No	Gonorrhea	Yes	No	Nervous Stomach	Yes	No
Broken Bones	Yes	No	Gout	Yes	No	Urethritis	Yes	No
Breast Disease	Yes	No	Hay Fever	Yes	No	(Non-gonococcal)		
Bronchitis	Yes	No	Hearing Loss	Yes	No	Obesity	Yes	No
Cancer	Yes	No	Heart Problems	Yes	No	Peptic Ulcer	Yes	No
Colitis	Yes	No	Chest Pains	Yes	No	(gastric or duodenal)		
Concussion	Yes	No	Murmurs	Yes	No	Phlebitis	Yes	No
Condyloma	Yes	No	Rheumatic Disease	Yes	No	(swollen leg veins)		
(genital warts)			Other _____			Rheumatic Fever	Yes	No
Depression	Yes	No	Shortness of Breath	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Hernia	Yes	No	Sinus Problems	Yes	No
Dizziness	Yes	No	Herpes (Genital)	Yes	No	Suicide Attempts	Yes	No
Drug Dependency	Yes	No	High Blood Pressure	Yes	No	Syphilis	Yes	No
	Yes	No	HIV	Yes	No	Sexual Transmitted		
						Disease	Yes	No

MALES

Prostate Problems Yes No
Lump in Testicles Yes No

FEMALES

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

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

Do you take medications, pills, or use other drugs regularly? _____ Yes _____ No

List below all drugs, including over the counter, birth control, laxatives and sleeping medications.

LIST:

Please list all Health Care Providers whom you see regularly.

Date received by Wellness Center Staff: _____

FAMILY HISTORY

MOTHER'S NAME (Please Print)

FATHER'S NAME

AGE

AGE

HEALTH STATUS

HEALTH STATUS

OCCUPATION

OCCUPATION

CAUSE OF DEATH

CAUSE OF DEATH

Number of 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	_____
Bleeding 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	_____

Allergies to any medicine? _____

Allergies to food? Allergies to insect stings, or other? _____

Any disability which requires assistance? _____

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/ Wellness center?

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

Student Signature: _____

Date: _____

Parental permit:

The law requires that parental permission to 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, except in extreme emergency, without parents being contacted and fully informed.

I give permission for diagnostic and therapeutic procedures and 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.

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 health care. 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	Blood Pressure
Abdomen	Liver	Spleen	Hernia
Skeletal	Spine	Joints	
Neuro.		Reflexes	Emotional

Laboratory Urinalysis

Sugar _____ Protein _____ Hematuria _____ SG _____
 Optional HCT. _____ Chol. _____

IMMUNIZATION HISTORY

NOTE: ALL residential students of Coppin State University must submit complete records to the Wellness Center by deadline dates (August and November). If born before 1957, you are considered immune to M-M-R (measles, mumps, rubella). If born AFTER 1957, you should have a re-vaccination for MMR before admission.

IMMUNIZATION DATES

1. MMR

	FIRST SHOT:	SECOND SHOT:	
Measles	_____	_____	To be valid, 2nd shot must be after 1980
Mumps	_____	_____	
Rubella			
(German Measles)	_____	_____	

2. DTP

Diphtheria, Tetanus, Pertussis _____	Childhood Series
TD Booster _____	Required within the past 10 years

3. TB Test of Chest X-ray _____
 PPD (If positive, X-Ray required) _____
Within the past year

4. Polio
 Childhood Series/Booster _____

5. Hepatitis B:

	_____	_____	
	1st.	2nd.	Final

Advised for Clinical Nursing Students

6. Varicella _____
7. Meningitis _____

Physician's Stamp and
Physician Signature: _____ **Date:** _____