PETER 3. FINE STUDENT NEALTH SERVICE
800 FLORIDA AVENUE, NE
WASHINGTON, DC 20002-369
(202) 651-5090 (V/TTY) **Fax (202) 651-5743**
SHS@gallaudet.edu

Dear Entering Student:

Congratulations on our acceptance to Gallaudet! The staff of the Peter J. Fine Student Health Service is ready to serve you. In order to serve you better, it is very important to provide Student Health Service with **ALL of** the following information:

MEDICAL HISTORY: The attached medical history form should be completed with the necessary information provided by your health care practitioner. A physical examination is also **required** for students intending to play sports. Please complete the entire form, every page, and ensure that the proper signatures are provided prior to your arrival.

IMMUNIZATIONS*: All students must provide a completed history immunizations. **In addition, the District of Columbia law requires that all students under the age of 26 at the time of enrollment must be immunized against preventable diseases listed in the immunizations part of this form (page 4, Section 1). It is mandatory that ALL students receive their immunizations BEFORE starting at Gallaudet.**

HEALTH INSURANCE: All full-time students must have health insurance that will cover both inpatient and outpatient services. If you do not provide proof of coverage from a private commercial insurance carrier or from a state-governed agency such as DC, MD, or VA Medicaid **ONLY**, you will be automatically billed for and covered by the Gallaudet Student Health Insurance Policy. This information must be provided by dates indicated below, ***You will be receiving detailed information regarding specific costs for the Gallaudet Health Insurance Policy for the 2008-2009 academic year beginning in early summer.***

This packet contains:

- Medical History Form (pages ***1-3)***
- Immunizations and physical examination form (page 4)

This **packet** must **be returned to Student Health Services no later than:**

June 1………………………for Fall Semester enrollment
November 1……………………..for Spring Semester enrollment

If you have an questions or concerns, please contact the Peter J. Fine Student Health Service at SHS@gallaudet.edu or (202) 65 1-5090 (Voice/TTY).

*Please note that in the near future the following immunizations will be required: Hepatitis A, Hepatitis B

SHS Use Only:
Reviewed by: ___
Date: __________

Current Photo Required.

Attached your photo here

STUDENT'S MEDICAL HISTORY FORM

Peter J. Fine Student Health Center
Gallaudet University
Washington, DC 20002-3695

A. GENERAL. INFORMATION

Name: ______________________________ Date of Birth: ______________
Last name First Name

Place of Birth: ______________________________ Sex: ________ Religion: ______________
City/State/Province

Marital Status: ☐ **M** ☐ **S** ☐ **W** ☐ **D** ☐ **Sep** **U.S.** Social Security Number (if available): ______________

Home Address: ______________________________City: ______________ State: _______ Zip: ________

Home Telephone: __ ______________Student I.D. Number: ______________ Email: ______________

List the names, addresses, and phone numbers or two people who should be notified In case of an emergency.

#1
Name:______________________Relationship__________

Full Address: ______________________
Phone Numbers: Home: ______________
Work: ______________
Email/Pager: ______________

#2
Name:______________________Relationship__________

Full Address: ______________________
Phone Numbers: Home: ______________
Work: ______________
Email/Pager: ______________

Authorization for Medical Treatment

I certify that the foregoing Information is true and complete to the best of my knowledge. I also realize that the information that I have given in the medical history section is confidential and for the use of the attending medical staff. I realize that my signature gives the Student Health Service permission to forward my name to the Office for Students with Disabilities if I have checked 'Yes' below.

I give permission to Gallaudet University to furnish such diagnostic, therapeutic, and operative procedures, voluntary immunization, and transportation as may be deemed necessary by its medical staff on my behalf. I am 18 years of age or older.

Student's Signature: ______________________________ Date: ______________

(NO TREATMENT WILL BE GIVEN IF NOT SIGNED)

Permission for Treatment of Minors

I Authorize Gallaudet University Student Health Service to obtain medical information from another medical facility on my behalf for continuity of care.

Signature: ______________________________ Date ______________________________

This consent form should be signed by the natural parent or legal guardian of minors (under 18 years) so that the appropriate diagnosis and treatment may be promptly carried out and so that no unnecessary delays will occur with emergency health service procedures. No major health services will be performed, except in an emergency, without parents or legal guardians being contacted and fully informed.

Transportation to area hospitals or diagnostic centers will be the responsibility of the parent/student.

Signature of Parent/Guardian:______________________Relationship: ______________Date: __________

Insurance Billing Authorization

I hereby give my permission for the Student Health Service to release any and all information related to processing health Insurance claims and obtaining payment for medical bills to appropriate doctors, hospitals, laboratories, insurance agencies, parents or guardians, or any other agents as necessary, including University personnel.

(Signature of Student if Over 18): ______________________________ Date: ______________

(Signature of Parent/Guardian if Student is Under 18): ______________________________ Date: ______________

The Student Health Service works in cooperation with the Office for Students With Disabilities in attempting to meet the needs **of** students with disabilities.
May the Student Health Service refer your name and Information regarding your disability to the Office for Students With Disabilities? ☐Yes ☐No

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Have you ever been a student at Gallaudet or any of its schools In the past? : ☐Yes ☐No

If "Yes," which school? ______________________________ and year______________

B. MEDICAL HISTORY (Please indicate problems you have now or may have had in the past.) If you have a serious medical problem for which you see a physician regularly, please enclose a written report of history and treatment from that physician.

	Please Circle
Acne	☐Yes ☐No
Alcohol Problem	☐Yes ☐No
Anemia	☐Yes ☐No
Asthma	☐Yes ☐No
Back Problems	☐Yes ☐No
Blackouts (fainting)	☐Yes ☐No
Bladder Infection (cystitis)	☐Yes ☐No
Bleeding Trait/Sickle Cell	☐Yes ☐No
Bronchitis – Chronic	☐Yes ☐No
Cancer (location: _________________)	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No
Chicken Pox	☐Yes ☐No
Chlamydia	☐Yes ☐No
Colitis	☐Yes ☐No
Condyloma (genital warts)	☐Yes ☐No
Deaf or Hard of Hearing	☐Yes ☐No
Age of Onset: __________ Cause: ______________	
Depression	☐Yes ☐ No
Diabetes	☐Yes ☐ No
Dizziness	☐Yes ☐ No
Drug Dependency (specify:__________)	☐Yes ☐ No
Dyslexia	☐Yes ☐ No
Ear infections	☐Yes ☐ No
Eating Disorders (anorexia, bulimia)	☐Yes ☐ No
Eczema	☐Yes ☐ No
Emotional or Mental Illness	☐Yes ☐ No
Epilepsy or Seizures	☐Yes ☐ No
Eye Problem (specify: ______________)	☐Yes ☐ No
Fibrocystic Breast Disease	☐Yes ☐ No
Gallbladder Problems	☐Yes ☐ No
Gonorrhea	☐Yes ☐ No
Gout	☐Yes ☐ No

	Please Circle
Hay Fever	☐ Yes ☐ No
Headaches (Migraine or Tension)	☐ Yes ☐ No
Heart Problem	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No
Rheumatic Heart Disease	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Enlarged Heart	☐ Yes ☐ No
Other ____	
Hepatitis (type: __________________________)	☐ Yes ☐ No
Herpes (genital)	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Hypoglycemia (low blood sugar)	☐ Yes ☐ No
Infectious Mononucleosis	☐ Yes ☐ No
Kidney Infections or Disease	☐ Yes ☐ No
Measles	☐ Yes ☐ No
Meningitis/Encephalitis	☐ Yes ☐ No
Mumps	☐ Yes ☐ No
Nervous Stomach	☐ Yes ☐ No
Obesity (greater than 20 lbs. overweight)	☐ Yes ☐ No
Ovarian Cyst	☐ Yes ☐ No
Pelvic Infection	☐ Yes ☐ No
Phlebitis	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Rubella (German measles)	☐ Yes ☐ No
Sinus Problem-Chronic	☐ Yes ☐ No
Syphilis	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Ulcer (gastric or duodenal)	☐ Yes ☐ No
Other Problems Not Listed	

C. ALLERGY MEDICATION

Are you allergic to:	**Please Circle**
Any Drugs	☐ Yes ☐ No
List ___________________________	
Any Foods	☐ Yes ☐ No
List ___________________________	
Environmental Agents	
1. Insects	☐ Yes ☐ No
2. Dust, Trees, Pollen, etc.	☐ Yes ☐ No

☐ Check here if you receive allergy shots.

The Student Health Service is available to administer allergy shots. We request that your health care provider give the first shot of the series and send us written detailed instructions for subsequent injections. We do not permit allergy shots to be self-administered in residence halls.

Are you using any medications regularly now? If so, what? (including dosage and how often) ________________________

____

____

D. VISION

How is your balance?	☐ Good	☐ Fair	☐ Poor
Do you have trouble walking or Staying upright in the dark?			☐ Yes ☐ No
How is your eyesight?	☐ Good	☐ Fair	☐ Poor
Do you wear glasses or contact lenses?			☐ Yes ☐ No

E. SEXUAL HISTORY

MEN	**Please Circle**
Have you ever had urinary problems?	☐ Yes ☐ No
Specify: ______________________	
Do you use condoms/"dental" dams?	☐ Yes ☐ No
WOMEN	
Menstrual History:	
Age of onset:________ Regular cycles?	☐ Yes ☐ No
Pregnancies? ________ No. of live births ________	
Methods of birth control:	
Do you use condoms/"dental" dams?	☐ Yes ☐ No
Date of last PAP smear: _____________________________	
Did your mother use the medication Diethyl Stilbestrol (DES) during her pregnancy?	☐ Yes ☐ No

F. SURGERY/HOSPITALIZATION/INJURY

Tonsils	☐ Yes ☐ No
Appendix	☐ Yes ☐ No
Hernia	☐ Yes ☐ No
Other operations or hospitalizations: _____________________________________	
Broken bones? Specify: ____________________	☐ Yes ☐ No
Dislocations? Specify: ______________________	☐ Yes ☐ No
Concussions/Head injures?	☐ Yes ☐ No
Other injuries? Specify: ____________________	☐ Yes ☐ No

G. SOCIAL HISTORY (This section to be filled out by student only)

Emotional **Please Circle**

Question	Please Circle
Have you received treatment or counseling for emotional problems?	☐Yes ☐ No
Have you ever tried to kill yourself?	☐Yes ☐ No
Do you vomit, or use laxatives or fluid pills to lose weight	☐Yes ☐ No
Do you feel like you can control all the demands in your life on daily basis?	☐Yes ☐ No
Do you usually feel sad, lonely, or depressed?	☐Yes ☐ No
Do you lose your temper often?	☐Yes ☐ No
Are you disturbed by any family problems?	☐Yes ☐ No
Do you have any problems sleeping?	☐Yes ☐ No

Drugs

Which of these drugs do you use?

	Never	Occass.	Freq.	Daily
Marijuana/Hashish	☐	☐	☐	☐
Downers (sedatives, tranquil-lizers, barbitu-rates)	☐	☐	☐	☐
Uppers (amphetamines, ice, diet pills)	☐	☐	☐	☐
Cocaine, Crack	☐	☐	☐	☐
Hallucinogens (LSD, PCP, THC, etc.)	☐	☐	☐	☐
Narcotics (heroin, codeine, dilaudid, etc.)	☐	☐	☐	☐

Alcohol **Please Circle**

How many times do you drink per week? ☐0-1 ☐2-3 ☐4-7

Approximate number of drinks per occasion ☐0-2 ☐3-4 ☐5-10

At what age did you start drinking alcoholic beverages? ________________________

How often would you estimate that you have driven a motor vehicle under the influence of alcohol? ☐Never ☐1-2 times ☐3-5 times ☐10 times

Have you ever felt you should cut down on your drinking? ☐Yes ☐No

Have other people annoyed you by criticizing your drinking? ☐Yes ☐No

Have you ever felt quilt about drinking? ☐Yes ☐No

Are you receiving treatment or have you ever received treatment for an alcohol problem? ☐Yes ☐No

Tobacco

Do you smoke? (cigarettes, cigars, or pipe) ☐Yes ☐No
Packs per day ________________

Chewing Tobacco/Snuff ☐Yes ☐No

How long have you smoked or used tobacco products?
____

H. Family History

FAMILY Print the names of your relatives, living or dead, in the list below.

DEAF Answer Yes, No, or H.H. for hard of hearing.

YEAR OF BIRTH HEALTH STATUS Give the year of birth for all relatives listed at the left and mark an (X) to indicate whether their health is good or poor.

ILLNESS Place an (X) in the appropriate column for any illness that the relatives listed at the left have now or have had.

DEATHS If a relative you have listed has died, write the cause of death and the age at death in the columns below.

FAMILY	DEAF	Year of Birth	Good	Poor	Alcoholism	Allergies/Asthma	Anemia	Bleeding Tendencies	Cholesterol Problems	Cancer/Tumor	Diabetes	Eplipsy	Glaucoma	Other Visual	Heart Troulbe	High Blood Pressure	Kidney/Bladder	Nervous Breakdown	Rheumatism or	Stomach/Duddental	Stroke	Tuberculosis	Cause of Death	Age
Father																								
Mother																								
Brother or Sisters																								
Spouse																								
Children																								
Grandparents																								