MANDATORY
Health History is mandatory for all undergraduate student, commutes or residents. This form must be completed and returned to Student Health Center with all required immunizations or your MSU registration may be denied

PRINT OR TYPE IN INK ONLY

This information is strictly for the use of the University Health Center and will not be released to anyone without your knowledge and consent. Please return this competed form to the Health Center.

Harriet A. Woolford Health Center
443-885-3236 Fax # - 443-885-8232

Today's Date:

HEALTH ENTRANCE CERTIFICATE

Last Name:	First Name:	Middle:	Student ID #:	Male ☐ Female ☐

Home/Permanent Address:	City or Town:	State:	Zip:	Home/Cell Number:

Marital Status	Month/Year Entering MSU	Date of Birth:

Country of Birth:	If Country of birth not in USA, specify date of arrival in USA

In case of emergency: Name, Address, Telephone # and relationship of Contact:

HEALTH INSURANCE INFORMATION:

Company or Organization:	Address:
Policy or Contract Number:	Expiration Date: Telephone:

Supplying insurance information on this form does NOT serve as the insurance waiver. Please complete the waiver at www.morgan.edu/studenthealthbenefits

PLEASE LIST ALL HEALTH CARE PROVIDERS

Please indicate any medical conditions for which you are currently being treated.

PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS
COMMENT ON ALL POSITIVE ANSWERS ON THE REMARKS SECTION

Height t Weight:

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No
Eczema			Shortness of breath			Recurrent constipation			Chicken Pox		
Acne			Asthma			Recent weight gain			Malaria		
Head Injury with Unconsciousness			Chronic Cough			Recent weight loss			Diabetes		
			Cystic Fibrosis			Hernia			Thyroid Problem		
Dizziness or fainting			Chest Pain			Hemorrhoids			Tumor, Cancer or Cyst		
Eye Trouble			Palpations (Heart)			Back problems			Sexually Transmitted Disease		
Ear problem			Rheumatic Fever			Disease or injury of joints			Herpes		
Hearing Difficulty			Heart Murmur			Bladder infection			Recurrent Diarrhea		
Nose problem			High Blood Pressure			Kidney infection			FEMALES ONLY		
Sinuses			Low Blood Pressure			Weakness, paralysis			Irregular Periods		
Hay fever			Anemia			Seizures			Severe Cramps		
Gum or Tooth trouble			Sickle Cell			Recurrent headaches			Excessive Flow		
Throat problem			Bleeding Disorder			Insomnia			Abnormal PAP		
Neck injury			Stomach trouble			Frequent anxiety			Pregnancy		
Bronchitis			Intestine trouble			Frequent Depression			Cystic Breasts		
Pneumonia			Gall Bladder trouble			Worry or nervousness			MALES ONLY		

Tuberculosis			Jaundice			Mononucleosis			Prostate Problems		
Vomiting			Hepatitis			Recurrent Diarrhea			Lump or mass in Testicles		

SURGERY: YES ☐ NO ☐ (i.e., appendectomy, tonsillectomy, hernia repair) Please list in the remarks section.

Do you take medication or use other drugs regularly? Yes ☐ No ☐ (List below all drugs, including over the counter, birth control pills, laxatives and sleeping medications)

REMARKS: _____

_____

_____

_____

SOCIAL HISTORY

Current	Past	Activity	Volume
		Cigarettes/chewing tobacco	_____cigs/day x ____yrs _____cans/week
		Smokeless tobacco	Amount:
		Alcohol	Avg. drinks/wk:
		Exercise	# times/wk :
		Recreational Drugs	Specify:
		Sports-Enhancing drugs	Specify:
Are you sexually active? Yes ☐ No ☐			If yes- Partner (s) are Male ☐ Female ☐ Both ☐
Do you use condoms? Yes ☐ No ☐ Occasionally ☐			Do you use seat belts/helmets Yes ☐ No ☐

The following immunizations ARE MANDATORY and must be documented with dates by the health care provider prior to registration.

Immunizations	Immunization Dates		
Measles, Mumps, Rubella	MMR #1:	MMR#2:	
TB Test (If positive a chest X-ray)	Date of Test and Result:		
Hepatitis B (bring documentation of first shot)	#1	#2	#3
Tetanus/Diphtheria (TD Booster within last 10 years)	Meningitis shot OR signed waiver (applies to RESIDENT HOUSING STUDENTS only)		
Name of Health Care Provider (Please Print):			Date:
Signature:			Telephone:

Family History

	Age	State of Health	Occupation	If deceased, Age of Death	Cause of Death
Mother					
Father					
Number of Brothers r			Number of Sisters:		

HAVE ANY OF YOUR BLOOD RELATIVES EVER HAD ANY OF THE FOLLOWING?

	Yes	No	Relationship		Yes	No	Relationship
Bleeding Disorder				Epilepsy			
Tuberculosis				Convulsions			
Diabetes				Cancer			
Kidney Disease				High Blood Pressure			
Arthritis				Stroke			
Stomach Disease				Suicide			
Asthma				Alcoholism/addiction			
Hay Fever				Hyperlipidemia			
Heart Attack/disease				High Cholesterol			

	Yes	No		Yes	No
Are you allergic to any medicines? (List in Remarks)			**Have you had any illness or injury or been hospitalized other than already noted (Give details)		
**Allergies (food, insect stings, other) (List in Remarks)			Do you have any questions regarding your health, family history, or other matters, that you would like to discuss now with a staff of the Health Center?		
**Any disability which requires assistance in evacuation in case of an emergency; assistance in the classroom or			Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine check-ups)		

other? (Give details)					
**Have you received treatment or counseling for stress, nervous condition, personally or character disorder, or emotional problems?					

If any of the above boxes are checked "Yes", the Office of Student Disability Support Services should be notified at 443-885-1719.

This form has been completed truthfully to the best of my knowledge:

Student Signature:	**Date:**
Reviewed by Morgan State University Health Center Staff:	**Date:**

PARENTAL/GUARDIAN CONSENT TO TREATMENT OF A MINOR:

I hereby authorize the professional staff of the Morgan State University Health Center to carry out or to request such diagnostic and therapeutic measures for my son/daughter as may be considered necessary or advisable by the treating provider. I also authorize the release to other physicians who may be treating my son/daughter, relevant medical information as to treatment provided my son/daughter through the Morgan State University Health Center. I understand I will be notified as soon as possible in the event of life-threatening illness or injury.

Signed:	**Relationship:**	**Date:**

Please use this space for remarks or additional information