

Medical History and Examination

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Wisconsin law states that you must have this form completed with an accurate immunization history
BEFORE you will be allowed to register.

Name _____ Date of Birth _____ Class _____
Home address _____ Home phone _____
City, State, Zip _____ Date form completed _____

INSTRUCTIONS:

1. Please fill out Part I of this form entirely (before physical examination).
2. Please complete Tuberculosis (TB) Screening Questionnaire (any 'yes' responses on questionnaire require physician completion of Tuberculosis (TB) Risk Assessment form).
3. Tetanus immunization within the past five years is recommended.
4. Measles, Mumps, Rubella – *TWO DOSES REQUIRED*.
5. This form must be filed with the University Health Service by August 1.
6. Lawrence University strongly recommends that you receive immunization against chicken pox if you have not had the disease as well as vaccination against meningitis.

Part I – Medical History

A. Immunizations. State date of most recent immunization or active disease:

Required - you must include dates (you cannot register without the state-required immunizations)

1. Tetanus _____
2. Diphtheria _____
3. Pertussis (Whooping Cough) _____
4. Polio _____
5. Measles #1 _____ #2 _____
6. Mumps #1 _____ #2 _____
7. Rubella (German Measles) #1 _____ #2 _____
8. Hepatitis B #1 _____ #2 _____ #3 _____

Optional

9. Other (Typhoid, Hepatitis A, etc.) _____
10. BCG _____
11. Chicken Pox immunization
(or natural disease) _____
12. Meningitis immunization _____
(strongly recommended)

(The series can be started at home and completed at Lawrence. Please list dates.)

B. List any drug (medication) allergies _____

C. Medical Problems. Check the conditions you have or have had and state the approximate date.

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdominal or intestinal disorder | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergy problems, e.g. hay fever | <input type="checkbox"/> Fatigue (chronic) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches (including migraines) | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Skin problem or disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Back problem | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swelling of hands, feet and/or eyelids |
| <input type="checkbox"/> Bone disease | <input type="checkbox"/> Hernia (rupture) | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Herpes (recurrent) | <input type="checkbox"/> Tuberculosis (or exposure to TB) |
| <input type="checkbox"/> Convulsions (seizures) | <input type="checkbox"/> HIV disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cough-persistent | <input type="checkbox"/> Kidney disease (including urine abnormalities) | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney or bladder infections | <input type="checkbox"/> Visual problem (excluding refraction) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malaria | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Weight change in the past year |
| <input type="checkbox"/> Drug (medication) reaction/allergy | <input type="checkbox"/> Menstrual problems | |
| <input type="checkbox"/> Ear or hearing problem | <input type="checkbox"/> Nightsweats | |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Persistent pain | |
| <input type="checkbox"/> Emotional trauma | <input type="checkbox"/> Physical handicap | |

(over)

D. **Surgery.** Please state date, type of operation, and name of hospital for all operations.

E. **Current status.**

Habits (state amount per day). Coffee _____ Tea _____ Tobacco _____ Alcohol _____
Medications. Please list all amounts being taken.

F. **Family history.** Please list any significant illnesses in your family (e.g., alcoholism, arthritis, cancer, diabetes, heart disease, high blood pressure, psychiatric illness).

G. **Insurance information.** *Please include copy of front and back of insurance card.*

Insurance carrier _____
Subscriber # _____ Group # _____
Name and address of insurance holder _____

Part II – Health Care Provider’s Examination

This form is not acceptable without a health care provider’s signature.

| Normal | | Abnormal | | | |
|--------|------------------------------|----------|-------|---------------------------------------|--------------------|
| _____ | General appearance | _____ | _____ | Height _____ | Weight _____ |
| _____ | Skin & lymphatics | _____ | _____ | Pulse _____ | B.P. _____ |
| _____ | Head, eye, ear, nose, throat | _____ | _____ | Vision: | |
| _____ | Neck | _____ | _____ | R. 20/ _____ | Corr. to 20/ _____ |
| _____ | Back | _____ | _____ | L. 20/ _____ | Corr. to 20/ _____ |
| _____ | Chest (including breasts) | _____ | _____ | Hearing: | |
| _____ | Lungs | _____ | _____ | R. _____ | _____ |
| _____ | Heart and vascular | _____ | _____ | L. _____ | _____ |
| _____ | Abdomen | _____ | _____ | Urinalysis (optional) _____ | |
| _____ | Pelvic (optional) | _____ | _____ | Complete Blood Count (optional) _____ | |
| _____ | Extremities | _____ | _____ | | |
| _____ | Neurological | _____ | _____ | | |

See Tuberculosis (TB) Screening Questionnaire & Tuberculosis (TB) Risk Assessment forms

Please describe any abnormalities:

Problem list and recommendations:

This is to certify that, in my opinion, _____ is in good health except as noted above, and is able to participate fully in academic work, physical education programs and intercollegiate athletics.

Health Care Provider’s signature _____ Date _____

Health Care Provider’s name (printed or typed) _____

Health Care Provider’s address _____
