

STUDENT HEALTH SERVICE
930 20th Street South, Suite 221
Birmingham, Alabama 35294-2042

Office Use Only: Duplicate _____ ____ Stars ____ Hold ____ Call Clearance

Full name _____ Student/Social Security No. _____
(Print) Last/Family First MI

The following students must fill this form out: Medical, Dental, Optometry, Nursing, Public Health, Health Related Professions (SHRP); Joint Health Sciences and all International Students. Non-degree-seeking-graduate, non-medical graduate and non-medical-undergraduate students do not complete this form; however, they need to turn in a copy of their MMR or Rubeola immunizations to the Registrar or Graduate School. Do not leave any blanks. Use N/A for not applicable. Please follow the directions carefully to insure that your form will not be rejected or delayed during processing. **You will not be allowed to matriculate until all 4 pages of this medical record have been completed and received by the Student Health Service at the above address. Incomplete or illegible health forms will not be accepted.** You are to complete pages 1, 2, top of page 3 and 4 entirely; the physician of your choice must complete the physical on page 3, or you may schedule a physical exam at Student Health for a nominal fee. Do not call to see if we have received your health form. Please use a return receipt when mailing. Your department will let you know if there is a problem with your health information.

(please **print** in ink or type)

1. Have you filled out this health application before? Yes ____ No ____
2. Have you ever been seen here at Student Health for an appointment, vaccine, or physical? ____yes____no
3. Are you an International Student? Yes ____ No ____
4. Sex ____ M ____ F
5. Age _____
6. Birthdate _____
7. Marital Status ____ S ____ M ____ D ____ W
8. Name of spouse if married _____
9. Number of Children _____
10. Maiden Name if applicable: _____
11. What Division of UAB are you entering? _____ Major: _____ Semester: _____
12. Name of other college previously attended: _____
13. Degree received _____
14. Local address: _____ Phone _____
15. Home address: _____ Phone _____
16. Name of parent or guardian _____ Phone _____
17. Their mailing address: _____
Street or P.O. Box City State Zip
18. Current email address: _____
19. Person to contact in emergency: _____ Phone _____

Health and Accident Insurance

Company _____ Policy Number _____
Address _____ Name of Policy Holder _____

If you have no insurance, you **will** be required to subscribe to the group policy through the Student Health Service.

Medical History

1. Do you have any medical problems? (such as asthma, diabetes, high blood pressure, etc.) Yes ____ No ____ If yes, please explain _____
2. Have you consulted a physician or been hospitalized within the past five years? Yes ____ No ____ If yes, please explain _____
3. Please list any surgery, acute or chronic illnesses, and significant injuries which you have had including dates _____
4. Are you taking any medications regularly at the present time, or have you taken any in the past (including oral contraceptives, antidepressants, allergy injections, etc.)? Yes ____ No ____ If yes, please list _____
5. Are you allergic to any medications or other substances? Yes ____ No ____ If so, list and describe reactions: _____

6. What is your present weight? _____ Your present height? _____ Have you had significant weight loss or gain recently? Yes ____ No ____ Please explain _____
7. Do you eat a balanced diet daily? Yes ____ No ____
8. Do you smoke? Yes ____ No ____ If so, how much, and for how many years? ____ Do you drink alcoholic beverages Yes ____ No ____ If so, type and number of drinks per week _____
Are you concerned about your utilization of alcohol or drugs? Yes ____ No ____
9. Do you have any restrictions on your physical activities? Yes ____ No ____ If yes, please explain _____
10. Is there any other information which would be helpful to the University Student Health Service in providing you with medical care? _____

Do You Have A Present Or Past History Of:

(check each item)

- | Yes | No | | Yes | No | |
|----------|------|---------------------------------|-----------|------|---|
| 1. ____ | ____ | Eye Problems | 20. ____ | ____ | Blood Clotting Problems |
| 2. ____ | ____ | Ear, Nose or Sinus Problems | 21. ____ | ____ | Congenital or Birth Defects |
| 3. ____ | ____ | Throat/Tonsillar Infections | 22. ____ | ____ | Cancer or Malignancy |
| 4. ____ | ____ | Infectious Mononucleosis | 23. ____ | ____ | Non-Malignant Tumor |
| 5. ____ | ____ | Asthma | 24. ____ | ____ | Thyroid Disorder |
| 6. ____ | ____ | Tuberculosis | 25. ____ | ____ | Diabetes |
| 7. ____ | ____ | Other Lung Infections | 26. ____ | ____ | Epilepsy or Seizures |
| 8. ____ | ____ | Rheumatic Fever | 27. ____ | ____ | Headaches |
| 9. ____ | ____ | Heart Murmur | 28. ____ | ____ | Depression |
| 10. ____ | ____ | Chest Pain | 29. ____ | ____ | Anxiety or Tendency to Worry |
| 11. ____ | ____ | Rapid Heart Beat | 30. ____ | ____ | Skin Problems |
| 12. ____ | ____ | High Blood Pressure | 31. ____ | ____ | Measles (Red or Rubeola) |
| 13. ____ | ____ | Ulcer (Stomach/Duodenal) | 32. ____ | ____ | Measles (German or Rubella) |
| 14. ____ | ____ | Recurrent Diarrhea | 33. ____ | ____ | Mumps |
| 15. ____ | ____ | Colitis/Enteritis | *34. ____ | ____ | Chickenpox (If no, vaccine may be required)* |
| 16. ____ | ____ | Hepatitis; Type, if known _____ | 35. ____ | ____ | Gynecological Problems |
| 17. ____ | ____ | Bladder or Kidney Infection | 36. ____ | ____ | Herpes/Other Genital Infection |
| 18. ____ | ____ | Kidney Stone | 37. ____ | ____ | Back Problems |
| 19. ____ | ____ | Anemia or Blood Disorder | 38. ____ | ____ | Bone or Joint Problems |
| | | | 39. ____ | ____ | Sports Related Injuries |

If any of the above questions are answered yes, please explain _____

*School of Medicine, Nursing, Optometry and Dental require antibody titer for those students who have no history of chickenpox or are uncertain of their immunity. Varicella vaccines are recommended on all students who show a negative titer for chickenpox.

Family History

Are both of your parents living? Yes ____ No ____ Are they in good health? Yes ____ No ____ If no, please explain _____

Numbers of siblings living _____ deceased _____ Cause of Death _____

Is there any history of the following conditions in your family?

Heart Disease	Yes ____	No ____	High Blood Pressure	Yes ____	No ____
Alcoholism	Yes ____	No ____	Psychiatric Disorders	Yes ____	No ____
Diabetes	Yes ____	No ____	Other problems	Yes ____	No ____

Previous Medical Records

List the name and address of your family or home physician.

Physician's Name _____ Telephone _____

Address _____

If you have any ongoing medical problems, please have your home physician send a written report or a copy of your medical records to the Medical Center Student Health Service.

STATEMENT AND CONSENT
(Students need to sign this section)

I hereby give to the Medical Center Student Health Service permission to release to the School in which I enroll at the University of Alabama at Birmingham, this and any additional information regarding my health status. I understand this to be used for enrollment and teaching purposes only. Further, I give my permission for any diagnostic procedures as may be deemed necessary by the Student Health Service.

X _____
Signature _____ Date _____ Printed Name _____

I certify that the information given on this form is true and correct, and I have no abnormality, limitation, or restriction not mentioned on this document. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information will constitute sufficient grounds for my dismissal from UAB. I agree to notify the Student Health Service of any change in my physical or mental health either prior to my registration or while I am a student at The University of Alabama at Birmingham, Medical Center. I acknowledge by my signature that I have read and understand these statements.

X _____
Signature _____ Date _____

You may schedule a physical exam at Student Health if you do not have a physician. Call 205.934.3580 and ask our receptionist for details.

TO THE PHYSICIAN: This medical information is confidential and remains in the Student Health Service. It is necessary for our medical care and advice regarding programs of study and medical clearance for enrollment. Please review medical history with student. Supplemental details are needed if any positive answers are given to questions 1-39 on page 2. Check normal or abnormal on physical exam and leave blank if not done.

Name _____ Social Security Number _____

Height _____ in. Weight _____ lbs. Temp. _____ F. Pulse _____ BP

Vision: O.D. _____ \ O.S. _____ \ O.U. _____ \ With Correction: _____ yes _____ no

(Wearers of contact lenses are advised to have a pair of glasses for alternative use.)

Ears: Is hearing normal? Yes _____ No _____ Are drums intact? Yes _____ No _____

Color Vision Screening (for medical students only please) Result _____ Date _____

	Normal	Abnormal		Normal	Abnormal
Skin			Abdomen		
Head, Face, Neck			Endocrine System		
Nose and Sinuses			Spine		
Mouth and Throat			Neurologic		
Teeth			Hernia		
Lungs and Chest			Genitalia		
Heart			Breasts		
Vascular System			Pelvic, if indicated		

Are muscle strength and function of extremities normal and all digits present? Yes _____ No _____

Comments: _____

Physician Signature: _____ M.D./D.O./N.P. Date _____
Month/Day/Year

*Physician must sign to get credit for this physical exam. Office Phone _____

NAME: _____ Student/Social Security No. _____
(Print) Last/Family First MI

IMMUNIZATION HISTORY

READ CAREFULLY:

You must fill this page out legibly and attach photocopy documentation of your immunizations to the back of this form. If you cannot find documented proof such as medical records, or certificates of immunizations, then you will be required to retake or titer test the undocumented immunization before you can matriculate. All students participating in the UAB Student Health Service are required to have a Tuberculin Skin Test and be immunized against Tetanus, Diphtheria, Rubeola, Rubella and Mumps within the time requirement noted below. All other immunizations are required unless exempted by the school to which you are enrolling. **Do NOT estimate your immunization dates.**

TUBERCULIN SKIN TESTING: We will only accept TB testing done in the United States. (International students must take a one-step TB test within three months prior to enrollment and regardless of prior BCG vaccination). Domestic students should have their testing within a year of their matriculation date. **Two Step TB testing required for all medical/health related students only.** (Two step TB testing requires 2 TB tests taken no less than one week apart and no longer than one month apart from each other.) **Note:** Only individuals with a past positive (10mm or more result) will need to provide us with a current chest x-ray. We will not accept a chest x-ray report in lieu of your TB test requirement.

1 Step TB Test: _____ Date _____ 2 Step TB Test: _____ Date _____
 Results: ___ Positive* (Record reaction in mm) _____ mm Results: ___ Positive* (Record reaction in mm) _____ mm
 ___ Negative _____ Negative

Additional 1 Step (For office use only): _____

***If reaction positive, or has been positive in the past, current (within past 3 months) Chest X-Ray Report is required:**
 CXR Date: _____ Results: _____

DT booster (Diphtheria/Tetanus) (Required within last 10 years) _____

UAB requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (Rubeola, MR, MMR) prior to registration. One dose must have been after 1980 and at least one of the doses must have been an MMR.

	Date Last Received <small>Month/Day/Year</small>	Where Received <small>(Who gave it and where)</small>
MMR (Rubeola, Rubella, Mumps) — primary** (Must have been given after 1 year of your birth)	1. _____	_____
MMR (Rubeola, Rubella, Mumps) — booster	2. _____	_____
Rubeola (Red Measles) if given separately	1. _____ 2. _____	1. _____ 2. _____
Rubella*** if given separately	1. _____ 2. _____	1. _____ 2. _____
Mumps if given separately	1. _____ 2. _____	1. _____ 2. _____
Varicella (Chickenpox)	1. _____ 2. _____	1. _____ 2. _____
Chickenpox Antibody titer if required:	Pos. _____	Neg. _____
Meningococcal Vaccine (strongly encouraged but not mandatory yet)	_____	_____

****Exempt if born prior to 1957**
*****School of Nursing requires titer if never immunized.**

DOCUMENTATION OF HEPATITIS TYPE B IMMUNIZATION (Usually required for medical/health related students only)

	Month/Day/Year	Where Received
Dose #1	_____	_____
Dose #2	_____	_____
Dose #3	_____	_____

Antibody titer required 1-2 months after the last dose of vaccine.

HEPATITIS TYPE B SURFACE ANTIBODY TITER (HBSAB) REQUIRED ON ALL MEDICAL/HEALTH-RELATED STUDENTS WHO HAVE COMPLETED THEIR VACCINE SERIES.

(Please attach a copy of your HBSAB Labsheet to this health form.)

	Date Drawn <small>Month/Day/Year</small>	Where Drawn
HBSAB Titer _____ Level _____ <small>(Pos/Neg)</small>	_____	_____

IF PAST HISTORY OF TYPE B HEPATITIS DISEASE:

	Date Drawn <small>Month/Day/Year</small>	Where Drawn
Type B Surface Antigen Titer _____ Level _____ <small>(Pos/Neg)</small>	_____	_____
Type B Surface Antibody Titer _____ Level _____ <small>(Pos/Neg)</small>	_____	_____

You must fill this page out in order to process your paper work efficiently