FRANKLIN & MARSHALL COLLEGE

Lancaster General Health
at Franklin & Marshall College

Student Wellness Center

931 HARRISBURG PIKE, LANCASTER 17603
(717) 544-9051 FAX (717) 735-9234
www.studentwellness@fandm.edu

HEALTH HISTORY FORM

INSTRUCTIONS AND INFORMATION:

1. **Completion of this form (all 8 pages) is mandatory for all new and all transfer students. Mail, fax or email your forms directly to the Student Wellness Center by July 1.**

FAMILY/LAST NAME | GIVEN/FIRST NAME | MIDDLE | GENDER | DATE OF BIRTH M / D / Y

HOME ADDRESS (NUMBER AND STREET) | CITY OR TOWN | STATE | ZIP CODE

PREFERRED EMAIL (FANDM EMAIL WILL BE THE EMAIL OF RECORD ONCE YOU ARRIVE ON CAMPUS) | HOME PHONE | STUDENT CELL PHONE

EMERGENCY CONTACT (RELATIONSHIP TO STUDENT) | CONTACT PHONE NUMBER (HOME/WORK)

INSURANCE (PLEASE ENCLOSE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD):

_____ **I plan to enroll in the School Sponsored Insurance plan**

_____ **If you plan on using your private insurance please check that your insurance will cover you in the Lancaster area. Visits to the Student Wellness Center are billed to insurance.**

_____ **If you have a high deductible plan or your insurance has limited coverage in the Lancaster area, consider purchasing the Complementary Care offer through the College (for details visit www.fandm.edu/health-services)**

INSURANCE CO. NAME

POLICY HOLDER NAME | ADDRESS | DATE OF BIRTH M / D / Y

POLICY OR ID# | GROUP #

PREFERRED LAB FOR YOUR INSURANCE

FOR OFFICE USE ONLY

DATE RECEIVED: _____ DATE COMPLETED: _____ DATE SCANNED: _____ MRN# _____

MEDICAL HISTORY:

PERSONAL

Please check if you currently have or have had a history of conditions listed below:
Please explain all yes answers on line provided.

YES	NO	UNSURE	
☐	☐	☐	Neurologic Conditions—headaches, migraines, seizures, history of concussion, etc.
☐	☐	☐	Lung Disease—asthma, recurrent bronchitis/pneumonia, tuberculosis, etc.
☐	☐	☐	Heart Disease—high blood pressure, murmurs, congenital defects, etc.
☐	☐	☐	Intestinal Disease—Crohn's, ulcerative colitis, irritable bowel syndrome, peptic ulcer disease, dietary sensitivities etc.
☐	☐	☐	Endocrine Disorders—thyroid conditions, diabetes, etc.
☐	☐	☐	Hematologic—anemia, clotting disorder, sickle cell
☐	☐	☐	High cholesterol
☐	☐	☐	Liver Disease—hepatitis, jaundice, gallbladder disease, etc.
☐	☐	☐	Dermatologic—problematic acne, rashes, etc.
☐	☐	☐	Orthopedic—joint or muscle conditions, arthritis, major injuries, etc.
☐	☐	☐	ENT—recurrent sinus infections, recurrent strep throat, ear infections, hearing deficits, etc.
☐	☐	☐	GYN—menstrual disorder, ovarian cysts, etc.
☐	☐	☐	Eye conditions

YES	NO	UNSURE	
☐	☐	☐	Depression / Anxiety / eating disorder
☐	☐	☐	ADD / ADHD
☐	☐	☐	Cancer
☐	☐	☐	Congenital abnormalities—birth defects, disabilities, etc.
☐	☐	☐	Other?
☐	☐	☐	Previous surgeries
☐	☐	☐	Have you ever had intercourse? If yes, how many different sex partners? Gender of sex partner?
☐	☐	☐	Have you ever had a sexually transmitted infection?
☐	☐	☐	Do you drink alcohol? If so, how many drinks / week on average
☐	☐	☐	Have you ever taken any illegal or recreational drugs, or prescription medicine not prescribed for you?
☐	☐	☐	Do you smoke? Cigarettes? Marijuana? E-cigs?
☐	☐	☐	Are you concerned about your weight? Too heavy? Too thin?
☐	☐	☐	Do you participate in regular exercise program?

FAMILY HISTORY (PLEASE SPECIFY FAMILY MEMBER)

YES	NO	UNSURE	
☐	☐	☐	Heart Disease Any family members with unexpected death prior to age 50?
☐	☐	☐	Lung Disease
☐	☐	☐	Diabetes
☐	☐	☐	Hypertension
☐	☐	☐	High cholesterol

YES	NO	UNSURE	
☐	☐	☐	Thyroid Disease
☐	☐	☐	Blood clots
☐	☐	☐	Cancer
☐	☐	☐	Anxiety / Depression
☐	☐	☐	Other

The above information is accurate and complete to the best of my knowledge.

Student signature _____

Date: _____

LAST NAME FIRST NAME MIDDLE INITIAL DOB M / D / Y

MEDICAL HISTORY:

CURRENT MEDICATIONS:

Please list all current medications, including prescribed, over the counter, supplements, birth control etc.

NAME OF MEDICATION	DOSE	HOW OFTEN

ALLERGIES:

Please list allergy and reaction

MEDICATIONS	REACTION

ENVIRONMENTAL:

ALLERGAN (BEES, POLLEN, MOLD, GRASS, ETC.)	REACTION

****NOTE:** If you plan to participate in varsity athletics, the NCAA requires that all athletes have documentation of their sickle cell/sickle trait status. Please attach a copy of your sickle screen (most U.S. states do this as standard newborn screen) if you plan on being a varsity athlete.

LAST NAME FIRST NAME MIDDLE INITIAL DOB M / D / Y

TUBERCULOSIS (TB) RISK ASSESSMENT—REQUIRED BY ALL STUDENTS

1. Have you ever had a positive tuberculosis skin test or blood test in the past? ☐Yes ☐No
2. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)? ☐Yes ☐No
3. Were you born in a country listed below?* ☐Yes ☐No
   If yes, did you arrive in the U.S. within the past 5 years? ☐Yes ☐No
4. Have you traveled or lived for more than one month in any country listed below?* ☐Yes ☐No
5. Have you ever had changes on a prior chest X-ray suggesting inactive or past TB disease? ☐Yes ☐No
6. Do you have a medical condition associated with increased risk of active TB if exposed: diabetes, chronic renal failure, leukemias or lymphomas, low body weight, HIV/AIDS, gastrectomy or intestinal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone>15mg/day for>1 month), other immunosuppressive disorders, or are you an organ transplant recipient? ☐Yes ☐No
7. Have you been a volunteer, employee or resident in a high-risk congregate setting such as a prison, nursing home, hospital, homeless shelter, residential facility or other health care facility in the past 12 months? ☐Yes ☐No
8. Do you have a history of illicit drug use? ☐Yes ☐No
9. Have you ever received BCG vaccine? ☐Yes ☐No

* Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, United Republic of Tanzania, Vietnam, Zambia, Zimbabwe

If you answer NO to all of the above questions, no further action is required. If you answer YES to any of the above questions, you are REQUIRED to have either Interferon Gamma Release Assay (preferred) or Mantoux tuberculin skin test (TST) *within 6 months prior to beginning classes, unless a previous positive test has been documented. Prior BCG does not exempt students from the requirements.*

TB SKIN TEST Use Mantoux test only **—OR— TB BLOOD TEST**

Date Planted: ____/____/____ M D Y

Date Read: ____/____/____ M D Y

_____mm induration

(If no induration, mark "0"

Quantiferon: ☐*

Other:_____

Date: ____/____/____ M D Y

Result: Neg. ☐ Pos. ☐

***Enclose copy of lab report**

CHEST X-RAY*

Chest X-Ray Date: ____/____/____ M D Y

☐Normal ☐Abnormal

***Required for positive skin or blood tests**

MEDICATION TREATMENT FOR TUBERCULOSIS

Drug: _____

Dose and Frequency: _____

Treatment completion date: ____/____/____ M D Y

**** Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- * Organ transplant recipients
- Immunosuppressed persons: taking >15 mg/d of prednisone for > 1 month; taking a TNF-α
- Persons with HIV/AIDS

* *The significance of the travel exposure should be discussed with a health care provider and evaluated.*

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetic mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

The College reserves the right to require further testing for tuberculosis screening based on risk. Students who study abroad or travel in high prevalence areas should be screened for tuberculosis after their return. Screening tests for tuberculosis are available at the Student Wellness Center.

The American College Health Association has published guidelines on TB screening of college students that are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information visit www.acha.org/topics/tb.cfm or refer to CDC's Q&A about TB at www.cdcnpin.org/scripts/tb/faq.asp#2
http://apps.who.int/ghodata

LAST NAME FIRST NAME MIDDLE INITIAL DOB M / D / Y

IMMUNIZATION RECORD

IT IS IMPERATIVE THAT YOU RECEIVE AND HAVE RECORDS OF REQUIRED IMMUNIZATIONS PRIOR TO COMING TO F&M. THERE WILL BE A CHARGE FOR ANY IMMUNIZATIONS RECEIVED AT THE STUDENT WELLNESS CENTER.

REQUIRED IMMUNIZATIONS:

Completed childhood series:

Tetanus/Diphtheria/Pertussis (date completed)..... _____/_____/_____ M D Y

Booster: **(Tdap)** (Date given) ..... _____/_____/_____ M D Y

(Td) (Date given) ..... _____/_____/_____ M D Y

Polio series (date completed)..... _____/_____/_____ M D Y

The following required vaccines require official proof of vaccine (medical documentation, etc.) OR blood test showing immunity.

Measles, Mumps, Rubella (MMR) — 2 verified doses or titers demonstrating immunity

Dose 1 given at age 12 months or later (date given)..... _____/_____/_____ M D Y

Does 2 given at least 28 days after dose 1 (date given)..... _____/_____/_____ M D Y

Blood test confirming immunity **(attach copy of lab result)**

Varicella (Chicken Pox) — 2 verified doses or titers demonstrating immunity

Dose 1 (date given)..... _____/_____/_____ M D Y

Does 2 (date given)..... _____/_____/_____ M D Y

Blood test confirming immunity **(attach copy of lab result)**

Meningococcal — quadrivalent vaccine — 2 doses if first dose was given prior to age 16 (1 dose if given after age 16)

Dose 1 (date given)..... _____/_____/_____ M D Y

Does 2 (date given)..... _____/_____/_____ M D Y

Highly recommended vaccines (please provide documentation (dates given) of any vaccines that you have received)

Hepatitis B — 3 vaccine series, recommend Ab titer after vaccine series if not previously done

#1 _____/_____/_____ M D Y #2 _____/_____/_____ M D Y #3 _____/_____/_____ M D Y

Hepatitis A — 2 doses #1 _____/_____/_____ M D Y #2 _____/_____/_____ M D Y

Human Papillomavirus Vaccine #1 _____/_____/_____ M D Y #2 _____/_____/_____ M D Y #3 _____/_____/_____ M D Y

Meningitis B vaccine (see meningitis information document on web page

#1 _____/_____/_____ M D Y #2 _____/_____/_____ M D Y [#3 _____/_____/_____ M D Y —if Trumenba]

Please attach copy of all previous immunizations if available

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MD/NP/PA SIGNATURE _____ DATE _____

(Signature acknowledges verification of immunization record and tuberculosis screening)

ADDRESS _____

_____

_____

PRINT LAST NAME _____

PHONE _____

FAX _____

Return all information to:

LG Health at Franklin & Marshall College
Student Wellness Center
931 Harrisburg Ave.
Lancaster, PA 17603
Phone: 717-544-9051
FAX: 717-735-9234
Email: studentwellness@fandm.edu

MENINGOCOCCAL DISEASE

All students must read the information below and sign appropriate line at the bottom

Meningococcal disease is a serious bacterial illness caused by the bacterium Neisseria Meningitis. It is the leading cause of bacterial meningitis (infection of the lining of the brain and spinal cord) in the 2-18yr old age range, but can also cause serious blood infections. The disease is spread by the exchange of respiratory (sneezing and coughing) and throat (saliva) secretions during close or lengthy contact with an infected individual. Fortunately it is not as contagious as viruses like the common cold or the flu. College freshman living in dorms are considered a high risk group for contracting meningococcal disease. The most common symptoms of bacterial meningitis are: high fever, headache, stiff neck. Other typical symptoms include confusion, nausea, vomiting, lethargy and rash.

There are approximately 1000-1200 cases of meningococcal disease in the United States each year. The fatality rate for meningococcal disease is 10-14% even with timely, appropriate antibiotics. Of these individuals that survive, up to 20% can have permanent disabilities resulting from the disease including; brain damage/learning disabilities, hearing loss, or loss of limb.

Prevention of Meningococcal Disease

The best way to protect yourself against meningococcal disease is through receiving the recommended vaccines.

It is recommended that all individuals between ages 11-18 receive 2 doses of quadrivalent vaccine (MCV4). Ideally, the first dose should be given between 11 and 12 with a booster given at 16. If a previous dose was given prior to age 16, it is recommended that a booster dose be given prior to entering college and living in a college dorm.

The quadrivalent vaccines are highly effective against serogroups A, C, Y, and W135. The majority of meningococcal cases in individuals older than 11 years of age in the US are caused by serogroups C, Y, and W.

Due to several recent outbreaks of Serogroup B disease, there are now two vaccines available against serogroup B

The CDC recently published the current recommendation put out by the ACIP (Advisory Committee on Immunization Practices) in that individuals greater than 10 years of age who are considered at risk for serogroup B infection should receive either the 2 dose Bexsero vaccine, or the 3 dose Trumenda vaccine.

Individuals at risk include:

- Individuals without a functioning spleen (spleen removed, or not functioning as in some cases of sickle cell disease);
- Individuals either born with or subsequently develop via autoimmune type conditions, complement component deficiencies; and
- Individuals who work in outbreak areas

Individuals age 16-23 outside these at risk groups received a Category B recommendation from the ACIP regarding the vaccine. This means that they may be vaccinated for short term protection based on individual decision making, such as College Students during a Serogroup outbreak.

Please note: It is a Pennsylvania State Law that all college students residing in a dormitory must either receive the meningitis vaccine (quadrivalent vaccine is the CDC and F&M recommended vaccine), or sign a waiver declining the vaccine for "religious or other reasons." *You will not be able to receive your room key on Move-in Day without submitting proof of the vaccine or the signed waiver.*

For more information on meningococcal disease or meningococcal vaccine, you can refer to the following websites:

www.acha.org/topics/meningitis.cfm

www.cdc.gov/meningitis/index.html

I have read the above information and provided documentation of receiving meningococcal vaccine on the previous page

Signature _____ Date_____

Print Name_____

Waiver: I have read and understand the information provided above regarding the risks of meningococcal disease and the availability and effectiveness of the vaccine. However, for religious or other reasons, I decline the meningococcal vaccine at this time.

Signature_____ Date_____

Parent _____ Date_____

(if student is under the age of 18)

Lancaster General Health
at Franklin & Marshall College

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Demographic Sheet for Electronic Health Records

(Please complete and send in with your Health History Forms)

Name: _____

Date of BIrth: _____

Social Security #: _____

Cell Phone #:_____

Can we call and leave a detailed message for you on your cell? _____

F&M Email Address: _____

First Language:_____

Do you need an interpreter? _____

Birth City: _____

Birth State: _____

Country of Origin:_____

Race (optional) Circle one:

American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, Other, Unknown, White

Ethnicity (optional) Circle one:

Hispanic/Latino, Non-Hispanic/Latino, Unknown

Are you a veteran? _____

Emergency Contact: Name: _____

Relationship to you_____ Their preferred phone # _____

Their preferred language _____ Interpreter needed? (Y/N) _____

If you are on your parent's insurance plan, please provide the name of the parent who holds the policy, including their date of birth.

Name: _____ DOB: _____

Address: _____