Cheyney University
Student Health History 2022

Dear Student:

Congratulations on your acceptance to Cheyney University! In order to provide students with the highest quality of medical care, the Cheyney University Health and Wellness Center requires the following information:

Please document your health information on the Health Evaluation form, which you can download and print from the University's website. Complete the Student Health History portion yourself and then have your healthcare provider complete the Physician's Report.

The Student Health History **completed by you**, must include:

- Family history
- Personal medical history
- Risk factors for Tuberculosis and screening requirements

The Physician's Report, **completed by your healthcare provider,** includes:

1. Tuberculosis Test (PPD) documentation is required by the Health and Wellness Center ONLY IF a student indicates risk factors on Tuberculosis Screening section of the Student Health History.

2. Immunization Records - **REQUIRED VACCINATIONS FOR ALL STUDENTS:**

    - **TD (Tetanus/Diphtheria) OR Tdap (Tetanus/Diphtheria/Pertussis) – Booster within the last 10 years.**
    - **MMR (Measles/Mumps/Rubella) – Two doses or report of positive titers**
    - **STUDENTS RESIDING ON CAMPUS MUST ALSO HAVE: Meningitis vaccination or signed waiver**

3. **A physical examination within the last 12 months of admission for all freshman students and within 36 months of admission for all transfer and graduate students.**

Please upload all completed forms to your housing application.

If you have any questions regarding the requirements, please contact the Health and Wellness Center at (610) 399-2260.

PLEASE REMEMBER THAT COMPLETION OF BOTH PAGES OF THE HEALTH EVALUATION FORM IS REQUIRED.

We look forward to partnering with you on your health and wellness at Cheyney University.

Sincerely,

CHEYNEY UNIVERSITY HEALTH AND WELLNESS CENTER

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FAMILY HISTORY									
Biological Family Member	**Age**	**State of Health**	**If Deceased, Cause of Death**	**Age at Death**		**Do you or any of your biological family members have:**	**Yes**	**No**	**Relationship**
Father						Cancer			
Mother						Diabetes			
Sibling M/F						Epilepsy, Seizures			
Sibling M/F						Hypertension			
Sibling M/F						Hearth Disease			
						Kidney Damage			
						Mental Health History			
						Thyroid Disease			

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Personal History – Have you had any of the below? If yes, please comment on all positive answers in the space provided below.

	Yes	No		Yes	No		Yes	No		Yes	No
Allergies:			**Eyes:**			**Neurological:**			**Skin:**		
Material/Goods/Food			Visual Problems			Dizziness/Fainting			Rashes		
Cardiovascular:			Corrective Lenses			Headaches			Skin Lesions		
Heart Problems			**Gastrointestinal:**			Anxiety			**Urinary:**		
Heart Murmur			IBS			Depression			STD		
High Blood Pressure			GERD			Insomnia			Frequent UTI		
Low Blood Pressure			Celiac Disease			ADD/ADHD			Hernia		
Bleeding Disorder			Diarrhea/Constipation			History of Head Injury			**Other:**		
Sick Cell Disease			**Gynecological:**			History of Concussion			Tobacco Use		
Ears, Nose Throat:			Severe Cramps			Seizures			Alcohol Use		
Hearing Loss			Irregular Periods			Autism Spectrum Disorder			Street Drugs		
Seasonal Allergies			Breast Problems			**Respiratory:**			Learning Disability		
Endocrine:			**Musculoskeletal:**			Asthma			Current/Past Military Service?		
Diabetes			Chronic Muscle Pain			Chronic Cough					
Thyroid Issues			Chronic Muscle Weakness								
			Chronic Back/Joint Pain								

Comments:

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<table>
<tr><td colspan="2">Tuberculosis Screening – Please review and CIRCLE any risk factor in each section that apply</td></tr>
<tr><td>Section 1: Possible symptoms of Tuberculosis? Unexplained weight loss, elevation of temperature for more than one week; night sweats; persistent cough for more than 3 weeks; cough productive of bloody sputum.</td><td>Section 4: If you were born in or in the last 5 years, you have lived or traveled for 30 days or more in any of the following areas with a high prevalence of Tuberculosis, as defined by the World Health Organization and the PA Department of Health:

Tuberculosis in WHO Regions:
--African Regions
--Region of the Americas
--South East Asian Region
--European Region
--Eastern Mediterranean region
--Western Pacific Region</td></tr>
<tr><td>Section 2: Risk factors for Tuberculosis Infection? Close contact with known case of infective Tuberculosis; use of illegal injected drugs; HIB (Human Immunodeficiency Virus) infection; health care worker; resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility); positive skin Tuberculosis test in the past.</td><td></td></tr>
<tr><td>Section 3: Risk factors for Tuberculosis Disease? Diabetes Mellitus; lymphoma, leukemia or cancer of the head, neck or lung; gastrectomy or jejuno-ileal bypass (gastric bypass surgery); greater than 10% below ideal body weight; silicosis (occupational lung disease); organ transplant recipient</td><td></td></tr>
<tr><td colspan="2">The Center for Disease Control and Prevention, the American College Health Association and the United States Public Health Service recommends that Tuberculosis skin testing be performed on all individuals who may be at risk of Tuberculosis.

Do any of these sections apply to you?
If yes, a TB test is required through a PPD skin test, IFGA, or chest radiography.
If no, you are not required to have the TB/PPD test*

*Some majors require a TB test to be completed regardless of the risks above. Please check with your major department.</td></tr>
<tr><td colspan="2">Student Signature: _____

Date: _____</td></tr>
<tr><td colspan="2">Rev. March 2019</td></tr>
</table>

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PRACTITIONER'S REPORT

Name: _____ Date of Birth: _____

Please review the Student Health History page and complete this page. This student has been admitted to the University. This information will be used as background to provide property health care if necessary.

Physician/Provider to complete IF AT RISK FOR TUBERCULOSIS (SEE SCREENING ANSWERS ON PAGE 1)

Tuberculin Skin Test:
Date Given ____/____/____
Signature: _____

Date Read ____/____/____
Signature: _____

Result ____mm-Positive: ____ Negative: ____
IF POSITIVE, MUST PROVIDE: CHEST RADIOGRAPHY WITHIN TWO YEARS (ATTACH X-RAY REPORT)

OR

IFGA Results _____
****Documentation IS REQUIRED if treatment was received for: a positive TB skin test, abnormal CXR or active Tuberculosis**

Medication: _____
Date Started ____/____/____
Date Completed ____/____/____

For University Use:
____ Reviewed
____/____/____ Date
_____
Signature of University Practitioner/Date

MANDATORY IMMUNIZATIONS – To be completed and signed by a health care provider OR attach copy of immunization history (MANDATORY IMMUNIZATIONS MUST BE INCLUDED BELOW)

MMR (Measles, Mumps, Rubella)	**OR**	**MMR Titer**	**TETANUS-DIPHTHERIA (Td or Tdap within last 10 years)**
Option 1 **Dose 1 – Immunized at 1 year of age or after** **Date: ____/____/____** **Dose 2 – At least 4 weeks after dose 1** **Date: ____/____/____**		**Option 2** **Date of Titer: ____/____/____** **A copy of the titer results must be attached (**if not positive, will need vaccinations)**	Td ____/____/____ or Tdap ____/____/____
Other Immunizations Recommended:			
Hep B Series #1 ____/____/____ #2 ____/____/____ #3 ____/____/____		Varicella #1 ____/____/____ OR Had disease ____/____/____	HPV #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

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MENINGOCOCCAL VACCINE – **PENNSYLVANIA STATE LAW PROVIDES THAT A STUDENT AT AN INSTITUTION OF HIGHER EDUCATION MAY NOT RESIDE IN A DORMITORY OR CAMPUS HOUSING UNIT UNLESS THE VACCINATION AGAINST MENINGOCOCCAL DISEASE HAS BEEN RECEIVED OR A STUDENT (PARENT OR GUARDIAN FOR MINORS) MAY SIGN A WRITTEN WAIVER VERIFYING THEY HAVE CHOSEN NOT TO RECEIVE THE MENINGOCOCCAL DISEASE VACCINATION FOR REGLIIOUS OR OTHER REASONS.**		
Meningococcal Vaccine (at least one dose after 16 is recommended Date: ____/____/____ Dose 1 Date: ____/____/____ Dose 2	OR	Meningococcal Waiver: I, _____, received and reviewed the information provided by Cheyney University regarding meningococcal disease. I am fully aware of the risks associated with meningococcal disease and of the availability and effectiveness of the vaccinations against the disease. _____ (Signature of Student or guardian if student is not 18) Date: ____/____/____
***IF VACCINE HAS NOT BEEN RECEIVED, THE WAIVER MUST BE SIGNED BY STUDENT/GUARDIAN IF IN CAMPUS HOUSING**		

PRACTITIONER'S REPORT (PAGE 2)

PHYSICAL EXAMINATION – To be completed by Practitioner	
Allergies: ☐ Unknown	Current Medications: ☐ None
B/P: ____/____ Pulse: _____ Corrected Vision: Right – 20/____ Left – 20/____ Past Surgeries/Hospitalizations: Yes ____ No ____ If yes, list: _____	Height: _____ Weight: _____ Other pertinent history:

Organ System	Abnormal	Normal		Abnormal	Normal
Head, Ears, Nose, Throat			Genitourinary – Hernia (Males)		
Eyes			Musculoskeletal		
Respiratory			Metabolic/Endocrine		
Cardiovascular			Neuropsychiatric		
Gastrointestinal			Skin		

(Please use additional sheet for comment/explanation, if necessary)

Is there any loss or serious impaired function of any paired organ?	Yes	No	Comment
Is the patient currently under treatment for any medical or emotional condition?	Yes	No	Comment
Do you have any recommendations regarding the care of this individual?	Yes	No	Comment
Recommendations of physical activity, i.e., PE, intramurals, ROTC, etc.	Limited	Unlimited	Comment

PRACTITIONER'S NAME (PRINT): _____

OFFICE ADDRESS: _____

LICENSE NUMBER: _____ PHONE: _____ FAX: _____

DATE: _____