

initial health *history*

To be completed by student.
All information is confidential.

Please print or type clearly. Please detach completed forms and return by **August 1** to:
Health Services, Mount St. Mary's College, 12001 Chalon Road, Los Angeles, CA 90049
(for Chalon students), or 10 Chester Place, Los Angeles, CA 90007 (for Doheny students).

Chalon Student
 Doheny Student

Name _____ Male
last first Female

Student ID# or Last 4 Digits of SSN _____ Date of Birth _____ Local Phone _____
mm/dd/yy

Local Address _____
street city state zip

Permanent Address _____
street city state zip

Permanent Phone _____ In case of emergency notify _____

Relationship _____ Phone _____ Address _____

Medical Insurance Plan _____ PPO _____ HMO _____

Family Background Has anyone in your immediate family or blood relatives had any of the following?

	Yes	No	Explanation
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervical or Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke or Heart Attack Before Age 50	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Personal History

	Yes	No	If yes, please specify
Are you currently under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any allergies, including allergies to any medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How many per day? _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How much per week? _____
Do you consider yourself overweight?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____
Do you consider yourself underweight?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____
Do you have or have you ever had anorexia or bulimia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	What type and how often? _____
Have you ever had a sexually transmitted infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Women:

Do you have annual gynecological exams with pap smears?	<input type="checkbox"/>	<input type="checkbox"/>	Date/result of most recent exam: _____
Have you ever been pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Dates/outcomes: _____
Are your periods regular?	<input type="checkbox"/>	<input type="checkbox"/>	
At what age did you start to menstruate? _____			How frequent? _____
How many days do they last? _____			Date of the first day of your last menstrual period? _____

Have you ever had or do you have any of the following?

	Yes	No	Explanation and dates
Alcohol and/or drug problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma or hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood clot or vein problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain or lung problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diagnosed migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digestive/abdominal problem/ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gynecological disorders or surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing loss/ear aches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur or other heart problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis, jaundice, liver problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recurrent anxiety, significant depression, other emotional illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recurrent bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any other significant surgery or surgical conditions? Please provide information you feel will be pertinent to your care.

I hereby certify the above answers are correct.

Student Signature _____ Date _____

Consent—Please read and also sign the following

This must be signed by the student, and, for minors (under 18 years of age), by parent or legal guardian. In cases of missing immunizations, illness and/or injury, authority and consent is given to Mount St. Mary's College to cause the examination and treatment of the above named student either at the Health Services Office or by outside physicians and medical facilities as are available. Consent is further given for necessary admission to and medical or surgical treatment in a hospital. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable student insurance policy will be paid directly by the undersigned student and parent or guardian and the College will not be responsible thereon. Consent is also given to release health requirement information for clinical placements to respective departments and/or clinical sites.

Student _____ Date _____

Parent/Legal Guardian _____ Date _____

physical *exam*

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Name _____ Date _____ Campus _____
last first

Student ID or Last 4 Digits of SSN _____ Birth Date _____ Program _____
mm/dd/yy

TO BE COMPLETED BY THE PHYSICIAN OR PROVIDER

Subjective Comments: _____

Urinalysis (dipstick)

Blood _____ Bili _____ Uro _____ Ketone _____ Protein _____
 Nitrate _____ Glucose _____ PH _____ Sp Grav _____ Leukocytes _____

Complete Blood Count Please attach copy of lab report.

Physical Exam

VITALS: B/P _____ Temp. _____ Pulse _____ Respiratory Rate _____
 Weight _____ Height _____ LMP _____

VISION: Uncorrected R _____ L _____ Corrected R _____ L _____

ALLERGIES: _____

	Within Normal Limits	Observations/Comments
Head and ENT		
Neck and Nodes		
Cardiovascular		
Respiratory		
Abdomen		
Rectal (optional)		
Musculoskeletal		
Neurological		
Skin		
Women:		
Breast exam (optional)		
Vulva/perineum/vagina (optional)		
Cervix (optional)		
Uterus/Adnexae (optional)		
Men:		
Genito-urinary (optional)		

Assessment: _____

Plan: _____

Medical Provider's Name _____ Phone _____
please print

Provider's Signature _____ Date _____