

**Dominican University of California**  
**Student Health Center**  
50 Acacia Avenue  
San Rafael, CA 94901  
Fax: (415)458-3755

**MEDICAL HISTORY**

Name \_\_\_\_\_ birth  
date \_\_\_/\_\_\_/\_\_\_ last first

Address \_\_\_\_\_  
street city state/country zip

Phone(\_\_\_\_)\_\_\_\_\_ Do you intend to live on campus ? yes \_\_\_\_\_ no \_\_\_\_\_

Circle term entering: Fall Spring Year \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

**CURRENT HEALTH CARE PROVIDER**

Provider's Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
City State Zip

Medical Insurance \_\_\_\_\_

*Contact your insurance company to determine if you will be able to use your coverage in San Rafael, California. Please bring your insurance card to school. **You will need to provide documentation of your medical insurance to the Business Services Office in Bertrand Hall((415) 257-0161) when you arrive on campus.***

**MEDICAL HISTORY** (To be completed by the student)

Do you take any medicines regularly? yes \_\_\_\_\_ no \_\_\_\_\_  
If yes, what are they? \_\_\_\_\_

Do you have allergies to medications, foods, bee stings, etc.? yes \_\_\_\_\_ no \_\_\_\_\_  
If yes, what are they? \_\_\_\_\_

How many drinks of alcohol do you have per day? \_\_\_\_\_ per week? \_\_\_\_\_

Do you smoke cigarettes? yes \_\_\_\_\_ no \_\_\_\_\_  
If yes, how many packs per day? \_\_\_\_\_

Do you use any other drugs? yes \_\_\_\_\_ no \_\_\_\_\_  
If yes, which ones? \_\_\_\_\_

Have you ever had any of the following conditions?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Alcoholism/substance abuse                                     | <input type="checkbox"/> Epilepsy/seizure disorder                              | <input type="checkbox"/> Kidney/bladder problems  |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Eye/vision problems                                    | <input type="checkbox"/> Muscle problems  |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Frequent headaches/migraines                           | <input type="checkbox"/> Neurological disorder  |
| <input type="checkbox"/> Back pain  | <input type="checkbox"/> Gall stones/bladder infection                          | <input type="checkbox"/> Physical disability  |
| <input type="checkbox"/> Bleeding/clotting disorder                                     | <input type="checkbox"/> Gynecological problems (i.e. menstrual irregularities) | <input type="checkbox"/> Psychological problem (i.e. depression, anxiety, suicide attempts) |
| <input type="checkbox"/> Breast disease   | <input type="checkbox"/> Hearing difficulties                                   | <input type="checkbox"/> Recurring abdominal pain   |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Heart disease/murmur                                   | <input type="checkbox"/> Shortness of breath  |
| <input type="checkbox"/> Chest pain with exertion                                       | <input type="checkbox"/> Hepatitis or liver problems                            | <input type="checkbox"/> Sickle-cell anemia   |
| <input type="checkbox"/> Concussion   | <input type="checkbox"/> High blood pressure                                    | <input type="checkbox"/> Skin problems (acne, eczema)                                       |
| <input type="checkbox"/> Cystic fibrosis  | <input type="checkbox"/> Immune deficiencies                                    | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Joint problems   | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Digestive/stomach problems                                     |   | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Dizziness/fainting   |   |   |
| <input type="checkbox"/> Used food restriction or excessive exercise for weight control |   |   |
| <input type="checkbox"/> Used diet pills, laxatives, or vomiting for weight control     |   |   |

Please elaborate on conditions marked above or include other significant health issues:

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Hospitalizations, operations or severe injuries: \_\_\_\_\_

**FAMILY HISTORY** (*Check if any members of your family have had the following*)

- |  |   |
|--|---|
| <input type="checkbox"/> Alcoholism/substance abuse          | <input type="checkbox"/> Kidney stones/problems                 |
| <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> Migraine headaches                     |
| <input type="checkbox"/> Bleeding disorder                   | <input type="checkbox"/> Sickle cell anemia                     |
| <input type="checkbox"/> Breast disease                      | <input type="checkbox"/> Stroke                                 |
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> Sudden death or heart attack before 50 |
| <input type="checkbox"/> Depression/anxiety/suicide attempts | <input type="checkbox"/> Thyroid problems                       |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Tobacco use                            |
| <input type="checkbox"/> Heart disease                       | <input type="checkbox"/> Tuberculosis                           |
| <input type="checkbox"/> High blood pressure                 |   |
| <input type="checkbox"/> High cholesterol                    |   |

**Please mail or fax this form to the address on the front. If you are taking any ongoing medications, please stop in or call the Student Health Center in Bertrand Hall ((415) 485-3208) within one month of your arrival on campus.**

I acknowledge that the above information is complete to the best of my knowledge. I understand that the Student Health Center does not provide comprehensive health care.  
(The information on this form is confidential.)

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Signature

date

**IMMUNIZATION FORM**

**Dominican University of California  
Student Health Center  
50 Acacia Avenue  
San Rafael, CA 94901  
Phone: (415) 485-3208  
Fax: (415) 458-3755**

All students must complete this form prior to enrollment. **All nursing students must turn in one copy to the Health Center and one copy to the nursing program office.** Documentation must be done by a licensed health care provider or a copy of official immunization record can be sent. Please speak to your health care provider if you have any questions about any of the immunizations. **Make sure that the documentation satisfies all your requirements.**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Month Day Year

Address \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Circle term entering: Fall Spring Year \_\_\_\_\_

Are you an international student? \_\_\_\_\_ Do you intend to live on campus? Yes \_\_\_\_\_ No \_\_\_\_\_

**The Meningococcal Vaccine is strongly recommended for freshmen intending to live on campus due to the increased risk in this population (CDC Guidelines, 2005). Date of vaccination, if given \_\_\_\_\_**

**Required of ALL students:**

- 1) Completed **Tuberculosis Screening** form **AND**  
2) **Two** doses of MMR (if born after January 1, 1975): Dates of vaccinations 1) \_\_\_\_\_ 2) \_\_\_\_\_  
**OR**  
Documentation of illness or blood titres showing immunity:

**Measles:** \_\_\_\_\_ Immune/Non Immune, **Mumps:** \_\_\_\_\_ Immune/Non Immune, **Rubella:** \_\_\_\_\_ Immune/Non Immune  
Date Circle one Date Circle one Date Circle one

**The following immunizations are REQUIRED for all nursing students.** They are **recommended** for all other students. For our records, please complete any of the following vaccines received.

**Tetanus** (every 10 years-give date last received) \_\_\_\_\_

**Hepatitis B** (3 doses- give dates vaccines received) 1.\_\_\_\_ 2. \_\_\_\_ 3. \_\_\_\_ \*Nursing Students: if last dose was administered more than 5 years prior to beginning clinical coursework a Hepatitis antibody must be done. \* **Hepatitis B Surface Antibody (date)** \_\_\_\_\_ Immune/Non Immune (circle one)

**Varicella** (2 doses) 1 \_\_\_\_\_ 2 \_\_\_\_\_ **OR Titre level** \_\_\_\_\_ Immune/Non Immune  
Date Date Date Circle one

Health Care Provider \_\_\_\_\_  
Print name Signature Date

Address \_\_\_\_\_ Phone \_\_\_\_\_

**TUBERCULOSIS SCREENING**  
 DOMINICAN UNIVERSITY of CALIFORNIA  
 STUDENT HEALTH CENTER  
 50 ACACIA AVENUE  
 SAN RAFAEL, CA 94901  
 Phone (415) 485-3208  
 Fax (415) 458-3730

**TO BE COMPLETED BY A HEALTH CARE PROVIDER:**

Name \_\_\_\_\_ date of birth\_\_\_\_/\_\_\_\_/\_\_\_\_  
last first month day year  
 Phone Number (\_\_\_\_) \_\_\_\_\_ Do you intend to live on campus? Yes\_\_\_ No\_\_\_

**TB Screening**

1. Does the student have signs or symptoms of active TB disease? (please circle) YES NO  
 If NO, proceed to question 2.  
 If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is the student a member of a high-risk group or is the student entering the health professions?\*\*\* YES NO  
 If NO, stop. No further evaluation is needed at this time.  
 If YES, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.
3. Tuberculin Skin Test:  
 Date given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date read: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Result: \_\_\_\_\_  
 (Record actual mm of induration, transverse diameter; if no induration, write "0")  
 Interpretation (based on mm of induration as well as risk factors): \_\_\_\_ positive \_\_\_\_ negative
4. Chest x-ray (required if tuberculin skin test is positive):  
 Result: \_\_\_\_ normal \_\_\_\_ abnormal Date of chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_

Health Care Provider: \_\_\_\_\_ Date \_\_\_\_\_  
Name Signature

Address: \_\_\_\_\_ Phone \_\_\_\_\_

\*\*\* Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. **Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list.** Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone 3 15 mg/d for 3 1 month) or other immunosuppressive disorders.

- |                         |             |                                |             |
|-------------------------|-------------|--------------------------------|-------------|
| <b>American Region:</b> | Denmark     | Iceland                        | New Zealand |
| Canada                  | Malta       | Sweden                         |             |
| Saint Lucia             | Finland     | Ireland                        |             |
| Jamaica                 | Monaco      | Switzerland                    |             |
| USA                     | France      | Italy                          |             |
| Saint Kitts and Nevis   | Netherlands | United Kingdom                 |             |
| Virgin Islands (USA)    | Germany     | Liechtenstein                  |             |
| <b>European Region:</b> | Norway      | <b>Western Pacific Region:</b> |             |
| Belgium                 | Greece      | American Samoa                 |             |
| Luxembourg              | San Marino  | Australia                      |             |