

University Health Center

Report of Health History

200 Manor Avenue
Langhorne, PA 19047-2990
Phone: 215.752.5800
Fax: 215.702.4423



This health form is to be completed, in its entirety, by all part-time students (11 credits or less) of Philadelphia Biblical University. Please be sure to type or print clearly. The information you provide is confidential and strictly for the use of the University Health Center. It will not be released to anyone without your approval and is not related to the admissions process.

Last Name _____ First Name _____ M.I. _____ Sex M F Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Social Security # _____ Marital Status S M Other _____

In case of emergency, please notify _____ Relationship _____ Home Phone _____ Cell Phone _____

Address (if different from above) _____ City _____ State _____ Zip _____

Business Address _____ Business Phone _____

Your Health Insurance Co. _____ Policy Number _____

Address _____ Contract Number _____

PERSONAL HISTORY—Please answer all questions, using page 2 to comment on all positive answers. Check "current" if condition currently exists. Have you ever had:

	YES	NO	CURRENT		YES	NO	CURRENT		YES	NO	CURRENT		YES	NO	CURRENT
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diseases/Injuries of Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Faintness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Cancer, Cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum/Tooth Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY			
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose/Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations (Heart)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP Smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>				Recurrent Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cystic Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monthly Breast Self Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (genital/oral)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MALES ONLY			
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lump or Mass in Testicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monthly Testicular Self Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic to any medications, foods, insect stings? Yes No If yes, please specify and describe your reaction: _____

Have you ever undergone surgery? Yes No If yes, please describe: _____

Do you take medication regularly? Yes No
If yes, please list all drugs taken, including over-the-counter drugs, birth control pills, laxatives, sleeping medications and vitamins: _____

PLEASE LIST PHYSICIAN(S), Dentist, Ophthalmologist and any other specialists who have provided you with health services:

Name and Practice	Phone	Name and Practice	Phone
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

YES NO

- A. Has your physical activity been restricted during the past five years? (Give reasons and duration.) YES NO
- B. Have you had difficulty with school, studies, or teachers? (Provide details.) YES NO
- C. Have you received treatment or counseling for a nervous condition, personality or character disorder, emotional problem, or eating disorder? (Provide details.) YES NO
- D. Have you had any illness, injury, or been hospitalized, other than already noted? (Provide details.) YES NO
- E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years, other than routine checkups? (Provide details.) YES NO
- F. Have you been rejected for, or discharged from, military service because of physical, emotional, or other reasons? (Provide details.) YES NO
- G. Do you have any questions regarding your health, family history, or other matters that you would like to discuss with a University Health Center staff member? YES NO
- H. Has your physician ever put you on a special diet? (If yes, describe.) YES NO
- I. For Females: Have you received the Quadrivalent Human Papilloma Virus Vaccine (HPV)? If yes, give date: / / YES NO

REMARKS OR ADDITIONAL INFORMATION:

Have you ever traveled overseas? Yes No

Name of Country _____	Immunizations _____	Date _____
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Have you ever been ill while overseas (cholera, malaria, typhoid, etc.)? Yes No If yes, please explain:

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	OCCUPATION	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?

DISEASE	YES	NO	RELATIONSHIP
Arthritis			
Asthma/Hay Fever			
Cancer			
Diabetes			
Epilepsy/Convulsion			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Mental Illness			
Stomach Disease			
Tuberculosis			

BY SIGNING BELOW, I: 1) affirm that all information in this document is correct and complete; 2) agree to inform the University Health Center of any changes in my health and in the information on this form; 3) give my consent that my parents or closest of kin be notified in the case of a situation which the University considers to be a medical emergency; and 4) give consent to be advised/cared for by a nurse, nurse practitioner, or doctor selected by the University Health Center regarding any medical needs that arise.

STUDENT'S SIGNATURE _____	DATE _____	REVIEWED BY A UNIVERSITY HEALTH CENTER STAFF MEMBER _____	DATE _____
AND PARENT, IF A MINOR _____		DATE _____	

PARENTAL CONSENT FOR MEDICAL TREATMENT FOR STUDENTS UNDER THE AGE OF 18

I, _____, give permission for my son/daughter, _____, to be
(NAME OF PARENT/GUARDIAN-PLEASE PRINT) (NAME OF STUDENT-PLEASE PRINT)
 advised/cared for by a nurse, nurse practitioner, or doctor selected by the University Health Center regarding any medical needs that arise.

Parent/Guardian's Signature _____ Date _____

University Health Center

Physician's Health Evaluation

200 Manor Avenue
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Phone: 215.752.5800
Fax: 215.702.4423



ALL STUDENTS MUST HAVE THIS PHYSICAL FORM COMPLETED PRIOR TO ATTENDING CLASSES AT PHILADELPHIA BIBLICAL UNIVERSITY.

TO THE EXAMINING PHYSICIAN: Please review the student's health history and complete **both sides** of this form. Please comment on all positive answers. The information you supply will not affect his or her status; it will be used only as a background for providing necessary health care. This information is strictly for the use of the University Health Center and Athletics Department and will not be released without student consent.

PLEASE PRINT

Student's Full Name _____ Sex M F

Height _____ Inches Weight _____ Lbs. BP _____ / _____

Corrected Vision:

Right 20/ _____ Left 20/ _____ Contact Lenses _____ Glasses _____

Urinalysis:

Sugar _____ Albumin _____ Micro _____

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Head, Ears, Nose, or Throat | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Respiratory | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Cardiovascular | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Gastrointestinal | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Hernia | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Genitourinary | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Musculoskeletal | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Metabolic/Endocrine | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Neuropsychiatric | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Skin | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is there loss or seriously impaired function of any paired organ? | <input type="checkbox"/> | <input type="checkbox"/> |

DESCRIBE FULLY:

Do you find any reasons that would make it medically inadvisable for the student to participate in supervised athletic activities?

Yes No If yes, please explain: _____

Recommendations for physical activity: Unlimited Limited

If limited, please explain: _____

Do you have any recommendation regarding the care of this student? Yes No

If yes, please explain: _____

Is the patient now under treatment for any medical or emotional condition? Yes No

If yes, please explain: _____

BY SIGNING THIS FORM, I HEREBY AFFIRM THAT THE INFORMATION CONTAINED HEREIN CONCERNS THE STUDENT LISTED ABOVE AND IS A TRUE ACCOUNT TO THE BEST OF MY KNOWLEDGE.

Physician's or Nurse Practitioner's Signature _____

Address _____

Print Name _____ Date _____

RETURN ALL INFORMATION TO:

Philadelphia Biblical University
University Health Center
200 Manor Avenue
Langhorne, PA 19047-2990

University Health Center

Record of Immunizations

200 Manor Avenue
Langhorne, PA 19047-2990
Phone: 215.752.5800
Fax: 215.702.4423



EVERY ITEM ON THIS PAGE MUST BE COMPLETED BY YOUR PHYSICIAN OR NURSE PRACTITIONER PRIOR TO ATTENDING CLASSES AT PHILADELPHIA BIBLICAL UNIVERSITY.

NOTE WELL:

- Dates are important** for all immunizations. Please include month, day, and year. This form is not complete without dates.
- For measles, mumps, or rubella, immunizations are **required** or you must have proof of immunity (either had the disease or laboratory confirmation of immunity).
- If your immunization records are not available, please have all your booster shots up to date or laboratory tests confirming immunity. (Contact your high school for a record of immunizations.)

Student's Full Name _____

Student's Date of Birth (Month/Day/Year) _____ / _____ / _____

■ **MMR***
(Measles, Mumps, Rubella)
First _____ / _____ / _____ Second required _____ / _____ / _____
If born before 1957, you are considered immune to measles, mumps, and rubella.

■ **POLIO**
First _____ / _____ / _____ Second _____ / _____ / _____ Third _____ / _____ / _____ Latest Booster _____ / _____ / _____
Childhood Series—give all dates

■ **DIPHTHERIA
TETANUS
PERTUSSIS**
First _____ / _____ / _____ Second _____ / _____ / _____ Third _____ / _____ / _____ Latest Booster _____ / _____ / _____
Childhood Series—give all dates (Must have been done within the last 10 years.)

■ **TB TEST**

	DATE GIVEN	DATE OF RESULTS	RESULTS
Mantoux Test	_____ / _____ / _____	_____ / _____ / _____	_____ mm
(Must have been done within the last year.)			
	DATE TAKEN	RESULTS	
Chest X-ray (if indicated)	_____ / _____ / _____	_____	

■ **HEPATITIS B****
First _____ / _____ / _____ Second _____ / _____ / _____ Third _____ / _____ / _____

■ **MENINGITIS*****
Meningococcal Vaccine
Tetravalent (A, C, Y, W-135) conjugate preferred
Date of Vaccination _____ / _____ / _____ Name of Vaccine _____

■ **CHICKEN POX******
(Varicella Vaccine)
First _____ / _____ / _____ Second _____ / _____ / _____

* The following CDC guidelines for measles must be followed. Students should have two doses of the live virus measles vaccine. The first dose needs to be given at 12 months of age or later (even one day before the first birthday is not valid). The second dose should be given at the time of school entry or later. If the vaccine is received at other than the suggested schedule, the two doses must be received at 12 months of age or later and be separated by at least one month. Current laboratory evidence of immunity is acceptable.

** Hepatitis B Virus (HBV) is a potentially life-threatening bloodborne pathogen. Centers for Disease Control and Prevention (CDC) estimate there are approximately 280,000 HBV infections each year in the U.S. (December 1991). Approximately 8,700 health care workers each year contract Hepatitis B, and about 200 will die as a result. In addition, some who contract HBV will become carriers, passing the disease to others. Carriers also face a significantly higher risk for other liver ailments which can be fatal, including cirrhosis of the liver and primary liver cancer. HBV infection is transmitted through exposure to blood and other infectious body fluids and tissues. Anyone with occupational exposure to blood is at risk for contracting the infection.

*** According to the CDC, there has been a sharp rise in meningitis outbreaks in the U.S. since the early 1990s, over one-third of them occurring in organizational settings, including schools and universities. Fortunately, this type of meningococcal infection may be prevented with Menomune, a simple and effective one-dose vaccine.

**** College students, without evidence of immunity (e.g., born in the U.S. before 1980, a history of the disease, two prior doses of the Varicella Vaccine, or a positive antibody titre) are recommended by the CDC to receive two (2) doses of the Varicella Vaccine.

BY SIGNING THIS FORM, I HEREBY AFFIRM THAT THE INFORMATION CONTAINED HEREIN CONCERNS THE STUDENT LISTED ABOVE AND IS A TRUE ACCOUNT TO THE BEST OF MY KNOWLEDGE.

Physician's or Nurse Practitioner's Signature _____
Address _____

Print Name _____ Date _____

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