MANDATORY
Health History is mandatory for all undergraduate students, commutes or residents. This form must be completed and returned to Student Health Center with all required immunizations or your MSU registration may be denied

Harriet A. Woolford Health Center
443-885-3236

This information is strictly for the use of the University Health Center and will not be released to anyone without your knowledge and consent. Please return this competed form to the Health Center.

PRINT OR TYPE IN INK ONLY

Today's Date:

HEALTH ENTRANCE CERTIFICATE

Last Name:	First Name:	Middle:	Student ID #:	Male ☐ Female ☐
Home Address (Number & Street Name)	City or Town:	State:	Zip:	Main Telephone:
Marital Status	Month/Year Entering MSU	Date of Birth:		
Place of Birth	If place of birth not in USA, specify date of arrival in USA			
In case of emergency: Name, Address and relationship of Contact:				Main Telephone:
In case of emergency: Business address of contact				Business Telephone

HEALTH INSURANCE INFORMATION:

Company or Organization:	Address:	
Policy or Contract Number:	Expiration Date:	Telephone:

PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS COMMENT ON ALL POSITIVE ANSWERS ON THE REMARKS SECTION								Height:		Weight:	
Have you had?	Yes	No		Yes	No		Yes	No		Yes	No
Eczema			Shortness of breath			Recurrent constipation			Chicken Pox		
Acne			Asthma			Recent weight gain			Malaria		
Head Injury with Unconsciousness			Chronic Cough			Recent weight loss			Diabetes		
			Cystic Fibrosis			Hernia			Thyroid Problem		
Dizziness or fainting			Chest Pain			Hemorrhoids			Tumor, Cancer or Cyst		
Eye Trouble			Palpations (Heart)			Back problems			Sexually Transmitted Disease		
Ear problem			Rheumatic Fever			Disease or injury of joints			Herpes		
Hearing Difficulty			Heart Murmur			Bladder infection			Recurrent Diarrhea		
Nose problem			High Blood Pressure			Kidney infection			FEMALES ONLY		
Sinuses			Low Blood Pressure			Weakness, paralysis			Irregular Periods		
Hay fever			Anemia			Seizures			Severe Cramps		
Gum or Tooth trouble			Sickle Cell			Recurrent headaches			Excessive Flow		
Throat problem			Bleeding Disorder			Insomnia			Abnormal PAP		
Neck injury			Stomach trouble			Frequent anxiety			Pregnancy		
Bronchitis			Intestine trouble			Frequent Depression			Cystic Breasts		
Pneumonia			Gall Bladder trouble			Worry or nervousness			MALES ONLY		
Tuberculosis			Jaundice			Mononucleosis			Prostate Problems		
Vomiting			Hepatitis			Recurrent Diarrhea			Lump or mass in Testicles		

SURGERY: Yes ☐ No ☐ (i.e., appendectomy, tonsillectomy, hernia repair) Please list in the remarks section.

Do you take medication, pills, or use other drugs regularly? Yes ☐ No ☐
(List in the remarks section all drugs, including over the counter, birth control pills, laxatives, and sleeping medications.)

PLEASE LIST ALL HEALTH CARE PROVIDERS

	Telephone:
	Telephone:
	Telephone:

SOCIAL HISTORY

Current	Past	Activity	Volume
		Cigarettes/chewing tobacco	_______cigs/day x_______yrs _______cans/week
		Smokeless tobacco	Amt:
		Alcohol	Avg. drinks/wk:
		Exercise	# times/wk :
		Recreational Drugs	Specify:
		Sports-Enhancing drugs	Specify:
Are you sexually active?			Yes ☐ No ☐
If yes- Partner (s) are			Male ☐ Female ☐ Both ☐
Do you use condoms?			Yes ☐ No ☐ Occasionally ☐
Do you use seat belts/helmets			Yes ☐ No ☐

The following immunizations ARE MANDATORY and must be documented with dates by the health care provider prior to registration.

Immunizations	Immunization Dates		
Measles, Mumps, Rubella	MMR #1:	MMR#2:	
TB Test (If positive a chest X-ray)	Date of Test and Result:		
Hepatitis B (bring documentation of first shot)	#1	#2	#3
Tetanus/Diphtheria (TD Booster within last 10 years)			
Meningitis shot OR signed waiver (applies to RESIDENT HOUSING STUDENTS only)			
Name of Health Care Provider (Please Print):			Date:
Signature:		Telephone:	

FAMILY HISTORY

	Age	State of Health	Occupation	If deceased, Age of Death	Cause of Death
Mother					
Father					
Number of Brothers:			Number of Sisters:		

HAVE ANY OF YOUR BLOOD RELATIVES EVER HAD ANY OF THE FOLLOWING?

	Yes	No	Relationship		Yes	No	Relationship
Bleeding Disorder				Epilepsy			
Tuberculosis				Convulsions			
Diabetes				Cancer			
Kidney Disease				High Blood Pressure			
Arthritis				Stroke			
Stomach Disease				Suicide			
Asthma				Alcoholism/addiction			
Hay Fever				Hyperlipidemia			
Heart Attack/disease							
High Cholesterol							

	Yes	No		Yes	No
Are you allergic to any medicines? (List in Remarks)			Have you had any illness or injury or been hospitalized other than already noted (Give details)		
Allergies (food, insect stings, other) (List in Remarks)			Do you have any questions regarding your health, family history, or other matters, that you would like to discuss now with a staff of the Health Center		
Any disability which requires assistance in evacuation in case of an emergency; assistance in the classroom or other? (Give details)			Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine check-ups)		
Have you received treatment or counseling for stress, nervous condition, personally or character disorder, or emotional problems?					

This form has been completed truthfully to the best of my knowledge:

Student Signature:
Reviewed by Morgan State University Health Care Staff Member:
Date:

PARENTAL PERMIT

This law required that parental permission be obtained for procedures on minors. The following consent from should be signed by the parent(s) so that such procedures may be promptly carried out with no unnecessary delays. However, no major operation will be performed, except in extreme emergency, without parent (s) being contacted and fully informed. I give permission for such diagnostic and therapeutic procedure as may be deemed necessary for my/son/daughter and also to present information concerning his/her medical condition to other responsible University Officials when deemed desirable.

Signed:
Relationship:
Date:

Please use this space for remarks or additional information