

University of Miami Miller School of Medicine
Health and immunization Record ACADEMIC YEAR 2008-2009

I. Student's Name	Last	First	MI	Date of Birth
II. Emergency Contact Person (name, address, phone, and relationship)				

Student C# Number _____

III. Conditions	Yes	No	Comments
Please check the appropriate box and write an explanation for every "yes" item in the accompanying space			Describe in detail. Enter item number before each comment. Use additional sheets if necessary.
1. Allergies			
2. Chronic or recurrent sinusitis			
3. Frequent or prolonged colds			
4. Frequent sore throat			
5. Recurrent/chronic swollen glands			
6. Immunologic disorders			
7. Chronic cough			
8. Asthma			
9. Respiratory problems			
10. Frequent or severe earaches			
11. Hearing loss			
12. Visual problems			
13. Glasses/contact lenses			
14. Chronic or severe headaches			
15. Frequent or severe dizziness			
16. Seizure/epilepsy			
17. Neurologic disorders			
18. High blood pressure			
19. Heart condition			
20. Heart murmur			
21. Rapid or irregular heart beat			
22. Frequent or severe chest pain			
23. Endocrine problems			
24. Thyroid problems			
25. Diabetes/hypoglycemia			
26. High cholesterol/triglycerides			
27. Jaundice			

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III. Conditions (continued)	Yes	No	Comments
Please check the appropriate box and write an explanation for every "yes" item in the accompanying space			Describe in detail. Enter item number before each comment. Use additional sheets if necessary.
28. Frequent/severe indigestion			
29. Frequent/severe abdominal pain			
30. Ulcer of stomach or duodenum			
31. Gallstones/inflamed gall bladder			
32. Chronic/recurrent diarrhea			
33. Inflammatory bowel disease/colitis			
34. Rectal bleeding			
35. Genital/gynecologic problems			
36. Chronic/recurrent urinary infection			
37. Kidney stones			
38. Protein/blood in urine			
39. Alcohol/substance abuse			
40. Psychological/emotional problems			
41. Anemia/blood disorders			
42. Tumor/neoplasm			
43. Chronic/recurrent skin disorders			
44. Arthritis/rheumatologic disorders			

IV. Infectious Disease Record (Insert the dates that you had the following)			
Disease Positive	Date	Disease Positive	Date
1. Measles/Rubeola		10. Amebic dysentery	
2. Encephalitis		11. Tuberculosis	
3. Diphtheria		12. Venereal disease	
4. Whooping Cough		13. Typhoid	
5. German Measles/Rubella		14. Rheumatic fever	
6. Hepatitis (specify type A B C D)		15. Chicken pox/Varicella	
7. Poliomyelitis		16. Mononucleosis	
8. Mumps		17. Malaria	
9. Meningitis (specify type)		18. Other (specify)	

V. Surgical History	
Type of Surgery	Year
1.	
2.	
3.	

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VI. Serious Injuries

List all serious injuries you have had. Indicate when they happened and any residual disability.

Injury Description	Year	Residual disability, if any
1.		
2.		
3.		
4.		

VII. Current Medical Conditions

List any current or chronic medical problems that you have. Indicate the date of onset and the current therapy.

Medical Condition	Date of Onset	Current therapy?
1.		
2.		
3.		
4.		

VIII. Current Medications

List all medications that you are currently taking for chronic or non-chronic conditions.

Medicine	Dosage	Condition

IX. Additional information and comments (use additional sheets if necessary)

I certify that to the best of my knowledge, all of the information I have provided is correct and complete.

PHYSICIAN'S REVIEW AND HEALTH EVALUATION

Student's Name: _____
(print or type)

Height: _____ **Weight:** _____ **B.P.:** _____ **DOB:** _____

Infectious Disease/Immunization Record

Condition _____ Date of Occurrence/Test _____

A. Tuberculosis screening required every year:

1. TB skin test(PPD): Positive__ Negative__ Record date of last two TB Skin Tests
Date Given: _____ Mm of induration _____
Date Previous Test _____ Mm of induration _____
2. Chest x-ray results(if PPD positive) Date: _____ Normal____ Abnormal_____
3. Treatment with anti-tuberculosis medication? Yes____ No_____
4. Indicate which medications and length of treatment from _____ to _____
5. Comments

B. Hepatitis

1. Hepatitis B sAB titer positive: Yes____ No____ Titer Date: _____
2. Hepatitis B vaccine completed: Yes____ No____

1ST dose date: _____
2nd dose date: _____
3rd dose date: _____

C. (MMR) Measles/ Mumps / Rubella/

1. Live MMR vaccine: 1ST dose date: _____
2nd dose date: _____

D. Rubeola/Measles

