THE CLAREMONT COLLEGES SERVICES

STUDENT HEALTH SERVICES

Claremont Graduate University

Medical History Report

All forms must be submitted to SHS: shsrecords@claremont.edu.

DATE: _____
Month Day Year

Name: _____ **Phone:** _____
Last First Middle

Gender: _____ **Date of Birth:** _____
Month Day Year

Address: _____
Street City State Zip

Person to notify in U.S. in case of an emergency: _____
Name Relationship Telephone

_____
Street City State Zip

Medical Insurance Coverage – Required for all students

To protect against the potential major costs of accident or severe illness, domestic and undocumented students are required to enroll in CGU's Student Health Insurance Plan (SHIP) unless eligible for a waiver. All F-1 international students are required to be enrolled in an Accident and Sickness Plan. Your policy information will be provided by CGU at the beginning of each academic term. ***All students with insurance outside of CGU's plans, please provide your insurance policy information below:***

Insurance Company**:** _____ Policy Number: _____

Phone number for reporting claims: _____

MEDICAL CARE AUTHORIZATION

I, the undersigned, hereby specifically authorize The Claremont Colleges Services Student Health Services health care provider or whomever he or she may designate to administer any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, in serious or major illnesses or injuries without prior notification of the undersigned or any other person and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending health care provider or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. I further agree that the Student Health Services may release any medical information to other campus health care providers at Monsour Counseling and Psychological Services who may be providing care.

SIGNATURE OF STUDENT: All students must sign.

Student Signature: _____ Date: _____

NOTE: A release of information must be signed and dated and on file for students 18 and older before any patient records and/or, billing information may be released/discussed with a student, parent, guardian, spouse, or healthcare provider. A form is available at https://services.claremont.edu/shs/docs/release-of-records-to-provider/ or at Student Health Services.

757 College Way, Claremont, CA, 91711
(909) 621-8222 • (909) 621-8472F

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Medical History (If yes, please explain in the space provided.)

1. Do you have any medical problems, current or past? No ☐ Yes ☐ _____
   _____
   _____
2. Have you has any surgeries? No ☐ Yes ☐ _____
   _____
   _____
3. Are you currently taking any prescription or non-prescription (over the counter) medications (including birth control/contraception, herbal remedies, and inhalers)? No ☐ Yes ☐ _____
   _____
   _____
4. Do you have any allergies (medication, food, stinging insects, vaccinations, etc.)? No ☐ Yes ☐ _____
   _____
   _____
5. Have you ever, or are you currently being treated for depression, anxiety, bipolar disease, eating disorder (anorexia or bulimia), drug or alcohol abuse, schizophrenia or self-injury? No ☐ Yes ☐ _____
   _____
   _____
6. Do you get regular exercise? No ☐ Yes ☐ Type: _____
   Frequency: _____ Duration: _____
7. Do you have any dietary restrictions? No ☐ Yes ☐ Vegetarian ☐ Vegan ☐ Other: _____
   Do you feel you eat a healthy diet? No ☐ Yes ☐
8. Do you drink alcohol? No ☐ Yes ☐ Average number of drinks per week: _____ Maximum drinks per day: _____
9. Do you use any recreational drugs? No ☐ Yes ☐ _____
10. Do you smoke? No ☐ Yes ☐ How many years have you smoked? _____ How many cigarettes per day? _____
    Do you want to discuss smoking cessation methods? No ☐ Yes ☐
11. How many hours of sleep do you average per night? _____
12. Are you currently sexually active? No ☐ Yes ☐
    (Sexually active means that you have been intimate or had sex with one or more partners, either currently or in the past. When a doctor asks if a patient is sexually active, they are usually trying to ascertain if the patient has had any sexually transmitted infections or pregnancy risks. If you answer yes, SHS recommends that you see a medical provider regarding contraception or testing for sexually transmitted infections.)
13. Do you have any current health concerns? No ☐ Yes ☐ _____
    _____
    _____
14. Have you ever been diagnosed with COVID-19? No ☐ Yes ☐

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STUDENT HEALTH SERVICES

To be completed by Health Care Provider Only:

Tuberculosis screening

All students from high prevalence areas for tuberculosis, or otherwise high-risk, must have a health care provider complete the form below or submit a report documenting a negative tuberculin skin test, a negative (normal) chest x-ray, or Interferon Gamma Release Assay (blood test) from a health care provider. A student with a positive tuberculin skin test, current or past, must submit a chest x-ray report. The report must be written in English, have the date of the skin test, x-ray, or blood test and have the name and the signature of the health care provider.

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____

If No, proceed to 2 or 3. ***If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.***

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.

Date Given: ____ /____ /____ Date Read: ____ /____ /____
M D Y M D Y

Result:_____mm of induration Interpretation: positive_____ negative_____

>5 mm is positive if the student has one of the risk factors below

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-α antagonist
- Persons with HIV/AIDS

Otherwise >10mm is positive

3. Interferon Gamma Release Assay (IGRA) may be used instead of Tuberculin Skin Test if available:

Date Obtained: ____ /____ /____ (specify method) QFT-G QFT-GIT other_____
M D Y

Result: Negative____ Positive____ Intermediate____

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____ /____ /____ Result: normal_____ abnormal_____
M D Y

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To be completed by Health Care Provider Only

Immunization Record: (Please fill out below OR attach copy of the immunization record)

Recommended

MMR (measles/mumps/rubella) – dates of vaccine or laboratory report of immunity

_____ #1 _____ #2 _____#3 or Report of Positive Immunity _____
(Persons born before 1957 are considered immune; all others should receive at least one dose of MMR vaccine)

Td or Tdap (tetanus/diphtheria/pertussis) – booster recommended every ten years

Date of last immunization _____

Varicella (chickenpox) – history of disease or dates of vaccine or laboratory report of immunity

_____ #1 _____#2 or Report of Positive Immunity _____ or Date of Disease _____

Hepatitis B --
_____ #1 _____ #2 _____#3

Hepatitis A --
_____ #1 _____ #2

Meningococcal Tetravalent (MCV4) Tetravalent conjugate (preferred) Tetravalent polysaccaride — Date of last immunization _____ Booster _____

Human Papillomavirus (2, 4, or 9 valent)
_____ #1 _____ #2 _____#3

Polio
_____ #1 _____ #2 _____#3 _____ #4 _____ Last Booster

Influenza - Date of last immunization _____

Name of Health Care Provider (Please print): _____

Provider Address:_____
Street ***City*** ***State*** ***Zip***

Provider Phone #: _____ ***Provider Fax#*** _____

Signature of provider: _____ ***Date:*** _____

Stamp of provider:

Monsour Counseling & Psychological Services would like to welcome you to our campus!
This is an exciting time in your life. In order to provide optimum mental health services for all of our students, we invite you to complete this optional brief survey.

Information provided in this survey is confidential and access to any and all information is strictly limited to healthcare professionals at Student Health Services and Monsour Counseling & Psychological Services.

NAME:_____ **College** _____

Have you experienced, or are you now experiencing, any of the following?
(Please check all that apply)

			Have Received Treatment		Treatment Included:	
	YES	**NO**	**YES**	**NO**	**Counseling**	**MEDS**
Anxiety	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐
Drug or Alcohol Abuse	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐
Other Mental Health Concern	☐	☐	☐	☐	☐	☐

Have you been hospitalized for the above condition(s)? Yes ☐ **No** ☐

Do you plan to continue or to begin receiving treatment? Yes ☐ **No** ☐
☐ **MCAPS (on campus)** ☐ **Other Mental Health Professional (off campus)**

If you would like to be contacted by a staff member at MCAPS after the fall semester begins, please indicate your preferred contact information here (cell phone or email):

_____

Please note: *Only give your contact information if you wish a staff member at MCAPS to contact you. Also please remember the security of email cannot be guaranteed, and as such it is not a confidential mode of communication.*

PLEASE RETURN COMPLETED FORM TO:
Student Health Services
757 College Way
Claremont, CA 91711
FAX (909) 621-8472