THE CLAREMONT COLLEGES SERVICES

STUDENT HEALTH SERVICES

Claremont Graduate University

Medical History Report

All forms must be mailed to SHS at 757 College Way, Claremont, CA 91711, faxed to (909) 621-8472 , or **uploaded directly to SHS.** Link to upload forms can be found at **https://bit.ly/2WfxT3m.**

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

Name:_____ **Name Chosen**: _____
Last First Middle

Gender:_____ **Pronouns:**_____ **Phone:** _____

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, all students are required to enroll in CGU's Student Health Insurance Plan unless eligible for a waiver or exemption. For waiver and exemption information, please visit https://my.cgu.edu/health-insurance. New students who plan to enroll in the university plan will receive their insurance information at the beginning of the academic term. Students with US based insurance, 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 they 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 they 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/wp-content/uploads/2020/08/Medical-Release-to-SHS.pdf or at Student Health Services.

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

THE CLAREMONT COLLEGES
SERVICES

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 ☐

Continue to next page

Serving: Pomona College 1887 • Claremont Graduate University 1925 • Scripps College 1926 •
Claremont McKenna College 1946 • Harvey Mudd College 1955 • Pitzer College 1963 • Keck Graduate Institute 1997

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

THE CLAREMONT COLLEGES 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.

A. TUBERCULOSIS SCREENING (Required)

1. Does the student have a history of a positive tuberculin skin test (PPD) in the past? ☐ **Yes** ☐ **No**

   If no, proceed to #2.

   If yes, include date of positive PPD, mm induration, date and results of most recent chest x-ray and documentation of any treatment received for latent tuberculosis. **Skin test should not be repeated.** Proceed to #2.

2. Does the student have signs or symptoms of active tuberculosis disease? ☐ **Yes** ☐ **No**

   If no, proceed to #3.

   If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

3. Is the student a member of a high-risk group? ☐ **Yes** ☐ **No**

Categories of high-risk students include those students who were born in or resided in 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 were born in or resided in countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided 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 ≥ 1 month) or other immunosuppressive disorders.

If you have answered no to questions 1-3, please stop.

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.

Tuberculin Skin Test: (Must be performed within 6 months of arrival on campus)

Date Placed:_____ Date Read: _____

Result:_____(Record actual mm of induration, transverse diameter; if no induration, write "0".Interpretation (Based on mm induration as well as risk factors.): ☐

Positive ☐ Negative

Or Interferon Gamma Release Assay (IGRA): Date Obtained:_____

(Specify Method): ☐ QFT-G ☐ QFT-GIT Other: _____

☐ Positive ☐ Negative ☐ Intermediate Result:

4. Chest x-ray result (Required only if tuberculin skin test in #3 or IGRA is positive): Date of CXR:_____

Result: ☐ Positive ☐ Negative

Continue to next page

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

THE CLAREMONT COLLEGES SERVICES

STUDENT HEALTH SERVICES

To be completed by Health Care Provider Only

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

Recommended

COVID-19

_____ #1 _____ #2

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

Revised 04/21