



GORILLA WELLNESS
for all your health needs

PSU Health Services
Pittsburg State University
1801 South Joplin
Pittsburg, KS 66762

Dear New PSU-Starter and Parents/Guardian,

Welcome to Pittsburg State University!

IMPORTANT: Pittsburg State University requires all new students to complete a **MEDICAL HISTORY FORM** as part of their enrollment process. This health information is strictly confidential and can be very valuable should you have a medical emergency while a student on campus. Completing and returning your medical history form NOW will expedite your health care at a later date.

Pittsburg State University does not have a required immunization policy prior to enrollment, but we do follow the American College Health Association's recommendations for appropriate vaccinations for persons entering college. It is very important that your immunizations be CURRENT AND ON RECORD. There is a place on the Medical History form for you to complete this information. Immunizations are available at the Student Health Center upon request. ***Be sure the dates are completed.***

Return the Medical History Form along with your other enrollment information to the Office of Admissions, Pittsburg State University, 1701 S. Broadway, Pittsburg, KS 66772-7520 or fax each side of form separately and send to 620-235-6003.. If you have any questions regarding the form or our services, feel free to contact us by phone at 620-235-4450.

Click on the link below for a PDF version to download and print (uses Adobe Acrobat)



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Please complete both sides of form and return by mail to:
Office of Admissions, Pittsburg State University, Pittsburg, KS 66762
Or fax each side separately to: 620-235-6003

Medical History Form

This information is strictly for the use of the Student Health Center and will not be released to anyone without the student's knowledge and written consent.

A. Personal Data (Please print or type below)

NAME: Last (family)	First	Middle	Birth Date	PSU ID #
Permanent Address			City, State, Zip	Permanent Phone Number
Pittsburg Address			City, State, Zip	Local phone Number
Country of Citizenship		Sex	PSU Entrance Date	
Current Physician		Address/City/State	Physician's Phone Number	
Health Insurance Provider			Student's Social Security Number	
Date _____			Student's Signature _____	

B. Emergency Data

In an emergency, call:	Relationship	Phone (Home)	(Work)
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PARENTS OF STUDENTS UNDER 18: I hereby authorize medical treatment for my child which may be advised or recommended by the medical staff of Pittsburg State University Health Services.

Signature of Parent (if student under age 18)	Date	Student's signature
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Allergy Information

Drug Allergies: _____

Allergies: _____

Current Medications (List all including birth control). _____

Past Hospitalizations/Surgeries

NAME: _____

ID# _____

Medical History

Do you have a past history of: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Ear Trouble/Hearing Loss | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sexually Trans Dis (STD) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Disease/Problems | <input type="checkbox"/> Sickle Cell Trait/Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Smoking (how long?) |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cough (chronic) | <input type="checkbox"/> Intestinal/Stomach Trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Joint Disease/Injury | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis, Infectious | |
| <input type="checkbox"/> Disability/Handicap | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Other | | |

Brief explanation of any marked:

Family History

- | | | |
|---|---|--|
| <input type="checkbox"/> Alcohol/Drug Abuse _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hypertension/Stroke _____ |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> Elevated Cholesterol _____ | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Death before 50 _____ | <input type="checkbox"/> Heart Disease _____ | |
| <input type="checkbox"/> Other | | |

Brief explanation of any marked:

Immunizations

It is very important that your immunizations be CURRENT AND ON RECORD. Be sure appropriate dates are completed. In a university setting, you will be in contact with many new people. Such diseases as mumps, measles, chicken pox and whooping cough still exist, all highly contagious, and can spread rapidly in a concentrated population such as a school. **** Please note the required meningitis vaccine for University Housing Residents.**

REQUIRED for University Housing residents

**MENINGOCOCCAL (Meningitis Vaccine)

- No meningococcal vaccine.
 Yes, meningococcal vaccine. Date _____

RECOMMENDED VACCINES:

MMR

- No MMR vaccination.
 1 MMR vaccination. Date _____

 2 MMR vaccinations. Dates _____
 Have you had Measles, Mumps, or Rubella disease?
 o YES (circle Disease(s) Measles Mumps Rubella)
 No MMR Disease.
 Reactive Rubella Titer. Date _____

RUBELLA VACCINE

Do not complete if you had 1 or more MMRs.

- Date _____

TETANUS/DIPHTHERIA

- Less than 3 DPT/TD vaccinations ever.
 More than 3 DPT/TD vaccinations ever.
 Date of last tetanus booster. Date _____

POLIO

- No polio vaccination.
 Primary childhood series.
 o 3 doses oral vaccine (OPV)
 o 4 doses injected (IPV)

CHICKEN POX (Varicella)

- Had chicken Pox Disease.
 1 Varicella vaccination. Date _____

 2 Varicella vaccinations. Date _____ Date _____
 No Varicella vaccination.

TUBERCULOSIS

Have you ever had a positive PPD tuberculosis skin test?

- No positive PPD?RB skin test.
 Yes positive PPD?TB skin test. Date _____
 * **Documentation required for following:**
 o Chest x-ray. Date _____
 o INH Therapy. Date _____

HEPATITIS B

- No Hepatitis vaccine.
 1 Hepatitis B vaccine. Date _____

 2 Hepatitis B vaccinations. Date _____

 3 Hepatitis B vaccination. Date _____

HEPATITIS A

- No Hepatitis vaccine.
 1 Hepatitis A vaccine. Date _____ Date _____

 2 Hepatitis A vaccines. Date _____ Date _____

PNEUMOCOCCAL (Pneumonia)

- No pneumococcal vaccine.
 Yes, pneumococcal vaccine. Date _____

Student's Signature