

Claremont University Consortium  
Student Health Services  
757 College Way  
Claremont, CA 91711  
(909) 621-8222

**Medical History Report**

\_\_\_ Claremont Graduate University  
\_\_\_ Keck Graduate Institute  
\_\_\_ Claremont School of Theology

DATE: \_\_\_\_\_  
Month Day Year

Name: \_\_\_\_\_  
Last First Middle

Phone: \_\_\_\_\_

Male Female  
(Circle One)

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 – Recommended for all students, required for International Students.**

It is strongly recommended that all students of The Claremont Colleges have medical insurance to protect against the potential major costs of accident or severe illness. A medical insurance policy is offered to all students enrolled at The Claremont Colleges. For information on this voluntary policy, contact The Student Health Services or the Registrar.

Please Check: \_\_\_\_\_ I am **not** covered by a medical insurance program.  
\_\_\_\_\_ The medical insurance program listed below covers me.

\_\_\_\_\_  
Name of Insurance Policy Number  
Effective Dates: From \_\_\_\_\_ To \_\_\_\_\_

**Preventative Immunization Program: Required Vaccines**

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

Date 1<sup>st</sup> dose \_\_\_\_\_ Date 2<sup>nd</sup> dose \_\_\_\_\_ or Report of positive immunity Date \_\_\_\_\_  
(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 required**

Date: 1<sup>st</sup> dose \_\_\_\_\_ Date 2<sup>nd</sup> dose \_\_\_\_\_ or Report of positive immunity Date \_\_\_\_\_

In addition, the following vaccines are recommended to prevent illness: influenza, meningococcal, human papilloma virus (HPV), hepatitis A, hepatitis B, and polio. Please see your health care provider.

---

**Medical History (if yes, please explain in space provided)**

1. Do you have any medical problems, current or past? No  Yes  \_\_\_\_\_

2. Have you had any surgeries? No  Yes  \_\_\_\_\_

3. Are you currently taking any prescription or nonprescription (over the counter) medications (including birth control/contraception, herbal remedies and inhalers)? No  Yes  \_\_\_\_\_

4. Do you have any allergies (medication, food, or stinging insects, vaccines)? 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 per day \_\_\_\_\_

9. Do you use any recreational drugs? No  Yes  \_\_\_\_\_

10. Do you smoke? No  Yes  how many years \_\_\_\_\_ how many cigarettes per day \_\_\_\_\_  
Do you want to discuss smoking cessation methods? \_\_\_\_\_

11. How many hours of sleep do you average each night? \_\_\_\_\_

12. Are you currently sexually active? No  Yes   
(Please see medical provider regarding contraception or testing for sexually transmitted infections)

13. Do you have any current health concerns? No  Yes  \_\_\_\_\_

**Concerns/ Comments** \_\_\_\_\_

---

---

---

## Tuberculosis screening

All international students from high prevalence areas for tuberculosis must have a health care provider complete the form below or submit a report documenting a negative tuberculin skin test or a negative (normal) chest x-ray from a health care provider. If a student has a positive tuberculin skin test (current or past), a chest x-ray report must be submitted. The report must be written in English, have the date of the skin test or x-ray, have the results of the testing 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- $\alpha$  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

Date \_\_\_\_\_

Name of provider \_\_\_\_\_

Address of provider \_\_\_\_\_  
\_\_\_\_\_

Phone # of provider \_\_\_\_\_

Email of provider \_\_\_\_\_

Signature of provider \_\_\_\_\_

Stamp of provider