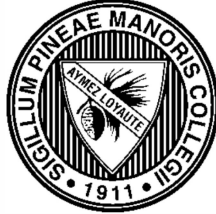




In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15c, Pine Manor College **REQUIRES** all students have on file a completed Immunization Form. **Any student failing to comply MAY NOT BE PERMITTED TO REGISTER FOR CLASSES OR LIVE IN THE RESIDENCE HALLS.** The Immunization Form must be filled out by a medical provider.

HEALTH REPORT Pine Manor College



Office of Student Affairs
400 Heath Street
Chestnut Hill, MA 02467-2332
Phone: 617-731-7151 Fax: 617-731-7102

For PMC STAFF USE ONLY

COMPLETED:

ALLERGIES:

OTHER:

MMR: #1 #2 Titer

Hepatitis B: #1 #2 #3 Titer

Tdap:

Varicella: #1 #2 #3 Titer

Hx dz

Meningitis: Vaccine Waiver

PPD: N/A Neg Pos

Chest X-ray INH

NAME: _____ **DATE OF BIRTH:** _____
Last First MI Month Day Year

PERMANENT ADDRESS: _____ **SOC. SEC #:** _____
Street

BIRTH PLACE: _____
City State Zip Country Country

GENDER: Female Male Transgender Other

HOME PHONE: _____ (____) _____ **CELL PHONE:** _____ (____) _____
Country Code if International or Area Code Country Code if International or Area Code

EMAIL: _____ **Date entering PMC:** _____

High School attended: _____ **Phone:** _____ (____) _____ **Year of HS graduation** _____
Country Code if International or Area Code

If transferring, college(s) attended _____ **Dates attended:** _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ **Relationship:** _____

Address: _____
Street City State Zip Country

Home or Cell Phone: _____ (____) _____ **Business Phone:** _____ (____) _____
Country Code if International or Area Code Country Code if International or Area Code

Email address: _____

PRIMARY CARE PROVIDER: _____
Name Phone

CONSENT FOR MEDICAL CARE

Student Signature (if 18 older) _____ Date _____

PARENT/GUARDIAN SIGNATURE REQUIRED if student is a minor (under 18 years of age)

I hereby grant permission to Pine Manor College's authorized representatives, to provide/seek medical care as my child, _____, may require while attending Pine Manor College. This includes referrals to outside providers, local hospitals, hospitalizations, anesthesia, and/or surgery should it be necessary in the event of serious illness or injury and I am not able to be reached.

Name of parent/Guardian (print) _____ Signature: _____ Date _____

Valid until student reaches the age of 18 years.

MEDICAL HISTORY

FAMILY HISTORY

	Present age or age at death	State of health or cause of death <i>(good, fair, or poor)</i>	Have any of your immediate relatives had any of the following:		
			No	Yes	Relationship
Father			Alcohol/Drug Problem		
Mother			Cancer		
Brothers			Diabetes		
			Heart Disease		
Sisters			High Blood Pressure		
			Kidney Disease		
Spouse			Neurologic Disease		
Children			Mental Illness		
			Tuberculosis		

PERSONAL HISTORY Do you have now or have you ever had (check all that apply):

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes (Type___) | <input type="checkbox"/> Kidney disease/stone | <input type="checkbox"/> Pneumothorax |
| <input type="checkbox"/> Anorexia nervosa/bulimia | <input type="checkbox"/> Emotional/mental illness | <input type="checkbox"/> Learning disability/ADD/ADHD | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Deaf/hearing impairment | <input type="checkbox"/> Loss of paired organ | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease /problem | <input type="checkbox"/> Blind/visual impair | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis (Type___) | <input type="checkbox"/> Malaria | <input type="checkbox"/> Positive TB test |
| <input type="checkbox"/> Cancer/malignancy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraines/chronic headaches | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ulcer/stomach issues |
| <input type="checkbox"/> Crohn's/ulcerative colitis/IBS | <input type="checkbox"/> HIV infection/disease | <input type="checkbox"/> Neuromuscular disease | <input type="checkbox"/> UTIs (frequent) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Impaired mobility/paralysis | <input type="checkbox"/> Phlebitis/deep vein clot | <input type="checkbox"/> Other_____ |

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates):

GYNECOLOGICAL HISTORY (Check all that apply):

Date of PAP test _____ Result: _____ Have you ever had an abnormal PAP smear? _____ Colposcopy? _____ Date _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Irregular periods /no periods | <input type="checkbox"/> Contraction: Pill___ Other___ | <input type="checkbox"/> Other sexually transmitted infections _____ |
| <input type="checkbox"/> Polycystic Ovary Syndrome (PCOS) | <input type="checkbox"/> Genital herpes (HSV) | <input type="checkbox"/> Pelvic inflammatory disease |
| <input type="checkbox"/> Breast lumps/fibrocystic | <input type="checkbox"/> Genital warts (HPV) | <input type="checkbox"/> Pregnancy: live births #____ Abortion/miscarriage #_____ |

IN-PATIENT HOSPITALIZATIONS (Please list all medical and/or psychiatric hospitalizations with dates and diagnosis):

MEDICATIONS: Please list all (prescriptions and over-the-counter) including birth control, asthma medications, antidepressants, etc.

ALLERGIES: None known Yes

If yes, please specify, including medications, insect venom, foods, etc.: _____ Type of reaction _____

How tall are you? _____

How much do you weigh? _____

Do you smoke cigarettes? No Yes

How many/day? _____

Are you concerned about your drinking use? No Yes

Do you drink alcohol? No Yes

How often? _____

When you drink, how many do you usually have?

Are you concerned about your drug use? No Yes

Do you use recreational drugs? No Yes

Which ones? _____

Do you often feel anxious or depressed? No Yes

Are you currently seeing a counselor/therapist? No Yes

Have you ever been to therapy? No Yes

Dates: _____

Do you exercise? Never 3-5 times/week Daily

What type of exercise? _____

