WHEATON COLLEGE STUDENT HEALTH SERVICES
MEDICAL HISTORY REPORT

SEE LAST PAGE FOR INSTRUCTIONS. **To be completed by Wheaton College Student; all information must be in English.**

Name:_____ ID# _____
Last name First name MI Preferred name

Address:_____
Street City State Zip Student's cell phone

Date of Entry:____/____ Date of Birth:____/____/____ Sex: ☐M ☐F _____
Mo Yr Mo Day Yr Maiden Name

Status: ☐Part-time ☐ Full-time ☐Undergraduate

Have you previously attended Wheaton College? ☐Yes ☐ No If yes, last year of attendance_____

In case of Emergency Notify:_____
Name **U.S. Phone Number** Relationship to student

FAMILY HISTORY

	Age	State of Health	Occupation (optional)	Age of Death	Cause of Death	Immediate Family Medical History	Yes	No	Relationship
Father						Autoimmune disease			
Mother						Cancer			
Siblings						Diabetes			
						Heart Disease			
						Kidney Disease			
						Seizures			
						Stroke			
						Tuberculosis			
						Psychiatric/mental health disease			
						Family history of sudden death before age 50 (cause unknown)			

PERSONAL HISTORY:

Have You Had?	**Y**	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
ADD/ADHD			Depression/Anxiety			Malaria			Sinus condition		
Anemia			Diabetes			Menstrual problems			Sleep Disturbance		
Asperger Syndrome			Disordered Eating			Mononucleosis			Stomach Disorder		
Asthma			Eye problem			Orthopaedic			Strep throat, recurrent		
Back Problem			Gallbladder disease			Pneumonia			Surgery		
Bipolar Disorder			Head injury			POTS			Appendectomy		
Bronchitis, recurrent			Headache, recurrent			PTSD			Tonsillectomy		
Cancer			Heart condition/Murmur			Recent International Travel			Other		
Celiac Disease			Hepatitis			Recurrent Concussions			Thyroid disorder		
Chickenpox			High Blood Pressure			Seizures			Tuberculosis		
Counseling			HIV/AIDS			Self Harm			Urinary tract infection		
Crohn's/Ulcerative Colitis			Kidney disorder			Sexually transmitted disease			Weight gain/loss, recent		

COMMENTS ON ALL "YES" ANSWERS: _____

_____

_____

HOSPITALIZATIONS/SURGERY: ☐ None
Reason(s)_____ Date(s)_____

List allergies & reactions to medications and foods: ☐ None _____

List medications/supplements taken regularly:☐ None_____

List accessibility needs: _____

Student's Signature (Required)_____ **Date** _____

PARENTAL CONSENT: If your student is <18 years of age, please complete the Consent for Minors, found on the SHS website

Wheaton College

Complete Only If New Intercollegiate Athlete

Athletics Medical History

Name:_____ Sport(s):_____ ID#: _____

DOB:_____ Sex:_____

GENERAL MEDICAL

1.	Has a doctor ever denied or restricted your participation in sports for any reason?	Yes/No
2.	Do you have or have you had any of the following? If "Yes" please circle.	Yes/No

Cancer	Asthma	Chicken Pox	Diabetes	Heat Illness
Hepatitis	Hemia	Pneumonia	Ulcers	Measles
Mono	High/Low Blood Sugar		Birth Deformities	
Rheumatic Fever	Kidney Disease		Tuberculosis	
Shortness of Breath	Hospitalization		Surgery	

3.	Are you currently taking any prescription or non-prescription (over-the-counter) medications?	Yes/No
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	Yes/No
5.	Are you taking supplements?	Yes/No
6.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes/No
7.	Do you or a family member have a history of asthma or exercise-induced bronchospasms?	Yes/No
8.	Were you born without, missing, or have lost function of an organ (ovary, kidney, eye, testicle, etc.)?	Yes/No
9.	Do you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?	Yes/No
10.	Have you had any chronic medical problems (chronic fatigue, thyroid condition, diabetes, etc.)?	Yes/No
11.	Do you wear glasses or contacts for athletics?	Yes/No
12.	Have you had any problems with your vision?	Yes/No
13.	Do you regularly use braces, pads, mouth guards, assistive devices, neck rolls, goggles, etc.?	Yes/No
14.	Have you ever received chiropractic care?	Yes/No

CARDIOLOGY

15.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	Yes/No
16.	Does your heart race or skip beats during exercise?	Yes/No
17.	Have you ever fainted or passed out during or after exercise?	Yes/No
18.	Has a doctor ever ordered a test for your heart (i.e. EKG, echocardiogram)?	Yes/No
19.	Has a doctor ever told you that you have:	
	High Blood Pressure	Yes/No
	High Cholesterol	Yes/No
	Heart Murmur	Yes/No
	Heart Infection	Yes/No
	Abnormal Heart Beat	Yes/No
	Sickle Cell Disease	Yes/No
20.	Do you have a family history of the following:	
	Sudden Death	Yes/No
	Death under Age 50	Yes/No
	Heart Disease	Yes/No
	Heart Attack	Yes/No
	Passing out / Syncope	Yes/No
	Sickle Cell Disease	Yes/No
	High Blood Pressure	Yes/No
	Marfan's Syndrome	Yes/No

ORTHOPEDIC

21.	Have you ever had an injury, illness, or surgery (i.e. sprain, strain, tendonitis, fracture, stress fracture, dislocation, etc.) that caused you to miss a practice or game?	Yes/No
22.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	Yes/No
23.	Have you had any fractures or stress fractures in the past two years?	Yes/No

Circle the following body part(s) that apply to the above three questions:

Head	Hand	Wrist	Neck	Chest
Lower Leg	Back	Hip	Ankle	Shoulder
Thigh	Foot/Toes	Arm	Elbow	Knee
Other Organs:				

24.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Yes/No

NEUROLOGICAL

25.	Have you ever experienced any of the following:	
	"Burner" or "Stinger"	Yes/No
	Head injury or concussion / How Many? _____	Yes/No
	"Blacked out" / "Knocked out"	Yes/No
	Confusion or memory loss due to hit to head	Yes/No
	Seizures / Epilepsy	Yes/No
	Hospitalization due to a concussion or mild traumatic brain injury	Yes/No
	Headaches with exercise	Yes/No
	Numbness, tingling, or weakness in your arms or legs after falling or being hit	Yes/No
	Inability to move a limb due to a hit or a fall	Yes/No

FEMALES

26. Have you ever had a period? Yes/ No Age of Onset? _____
27. How many periods have you had in the past year? _____
28. Interval between periods? _____ Duration of periods? _____
29. Are you on medication for your periods? Yes/No
    If "Yes", name of medication _____
30. Have you gained or lost more than 10 lbs. in the past year? Yes/No
31. Are you happy with your weight? Yes/No
    Explain _____
32. Are you trying to gain or lose weight? Yes/No
33. Has anyone recommended you change your weight or diet? Yes/No
34. Do you limit or carefully control what you eat? Yes/No

Explain "Yes" answers here (Please number the answer.)

_____

_____

_____

_____

_____

_____

_____

_____

Student Athlete Signature_____ Date _____

WHEATON COLLEGE, IL MEDICAL EXAMINATION FORM

This form will meet the medical exam requirement for general entrance and athletic participation. The medical examination must be within one year prior to start of the school year, unless student is an Intercollegiate Athlete, in which case the medical exam must be done 6 months or less prior to start of the school year.

TO THE EXAMINING MEDICAL PROVIDER┼. Please review the student's medical history, complete the medical examination form, and comment on all abnormal answers. Please add any laboratory diagnostic exams that are age/medical history appropriate.

Name_____ **Student ID #**_____ **□ M □ F Date of Birth**_____

Wt.	Ht.	BMI Please use the CDC.gov BMI calc.	Pulse	B/P
LMP date:	Regular □Yes □No	How many periods in a year?	Medications:	
Vision Corrected:_____ Uncorrected: _____	R 20/_____ L 20/_____	Contact Lenses: Yes | No Glasses: Yes | No	Allergies:	Food Allergies:

Clinical Evaluation

Check each item in appropriate column, at right. Enter "N.E." if not evaluated.	Normal	Abnormal		Musculoskeletal Exam	Normal		Abnormal (Indicate L/R)
1. Appearance				C-Spine			
2. Skull, Scalp, Face, Neck, Thyroid				Thoracic, Lumbar, Sacral Spine			
3. Nose and Sinuses					L	R	
4. Mouth (tongue, gingivae, teeth)				Shoulders			
5. Throat and Tonsils				Elbows			
6. Ears (Int. and Ext. canals)							
7. Eyes (pupils, E.O.M., conjunctiva)				Wrists			
8. Lungs and Chest (include Breasts)				Hand/Fingers			
9. Heart (rhythm, sounds, and Murmurs. Examine in sitting, recumbent, and left recumbent positions before and after exercise.)				Hips			
10. Abdomen/Pelvis and Viscera (include hernia)				Upper Legs			
11. Endocrine System				Knees			
12. G-U System (optional for females) males: testes				Lower Legs			
13. Skin				Ankles			
14. Lymphatic Glands				Feet/Toes			
15. Neuro/Psych				Other:			

Required: Recommendations for physical activity for intercollegiate, intramurals, club sports, travel abroad, general education requirements, internships. (Please complete or student cannot compete/participate):

_____Cleared without restriction

_____Cleared, with recommendations for further evaluation or treatment for: _____

┼ If this student is a NCAA intercollegiate athlete, he or she must have a sickle cell screening through blood test submitted to the Wheaton College Athletic Department.

┼Intercollegiate Athletes must complete Medical Examination by a M.D. or D.O per NCAA rules and Wheaton College Athletic Department.

┼M.D., D.O., PA, or NP Signature_____ Date_____ Phone _____
(Circle one of the above)

Medical Providers Name (please print or use stamp):_____ Fax:_____

Address: _____

Name:_____ **Student ID #**_____ **Date of Birth:** _____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Student: please fill out and submit form to SHS as this is part of your entrance medical requirements, even if you have not had any prior testing.

Prior Testing: Have you had a TB skin test (PPD)? ☐ No ☐ Yes If yes, result: ☐ Negative ☐ Positive Date:_____ Have you had a TB blood test (IGRA)? ☐ No ☐ Yes If yes, result: ☐ Negative ☐ Positive Date:_____	
Please answer questions 1-16 and provide an explanation if the answer is "YES."	**Explanation**
1. Have you ever been told by a doctor or healthcare provider that you had active TB?	□ **Y** □ **N**
2. Have you ever taken medication for TB? Which medication(s)? What year?	□ **Y** □ **N**
3. Have you ever had a BCG vaccine for TB? (BCG does not exempt you from this requirement)	□ **Y** □ **N**
4. Have you ever been told by a healthcare provider that your immune system is not working right or that you cannot fight infection? (e.g. immune disorder or illness)	□ **Y** □ **N**
5. Have you cared for, or lived with, anyone diagnosed with active TB disease in the past year?	□ **Y** □ **N**
6. Have you worked or volunteered in a setting where TB may be more common, such as a homeless shelter, nursing home, group home, or prison, in the past year?	□ **Y** □ **N**
7. In what country were you born?_____	
8. If you were not born in the USA, since what year have you been in the USA? _____	
9. Have you lived in any other country for greater than one year? □ **Y** □ **N** If yes, where and when? _____	
10. Have you traveled outside the USA in the past year? □ **Y** □ **N** If yes, please provide the following information. Country_____ Length of stay (in days/weeks) _____ Date of return _____ Country_____ Length of stay (in days/weeks) _____ Date of return _____ Country_____ Length of stay (in days/weeks) _____ Date of return _____	
11. Have you received a live vaccine in the past 6 weeks? (e.g. measles, mumps, rubella, chickenpox, or shingles)	□ **Y** □ **N**
12. Persistent coughing (3 weeks or more)	□ **Y** □ **N**
13. Coughing up blood or bloody sputum	□ **Y** □ **N**
14. Night sweats (soak the sheets)	□ **Y** □ **N**
15. Unexplained weight loss?	□ **Y** □ **N**
16. Unexplained, excessive fatigue?	□ **Y** □ **N**
17. Fever of unknown origin?	□ **Y** □ **N**

SHS will review this form and contact you if you need an individual plan for further testing. Testing mayinclude a PPD skin test(s) or an IGRA blood test. These services may be available through Student Health Services.

For non-SHS Medical Providers, please use TB SCREENING SUPPLEMENT FOR MEDICAL PROVIDERS (page 6) to provide additional documentation.

Name:_____ **Student ID #**_____ **Date of Birth:** _____

IMMUNIZATIONS REQUIRED BY WHEATON COLLEGE

Please attach an **official immunization report**. Report must include healthcare provider signature or office stamp. Immunizations are required by the State of Illinois for all incoming students. Other immunizations are recommended by Wheaton College. Alternatively, this form may be completed in English, including month, day, and year for each immunization.

*TETANUS/DIPHTHERIA/PERTUSSIS

3 doses required. One dose must be Tdap received within 10 years prior to term of current enrollment. At least six months required between 2nd and 3rd dose.

DIPHTHERIA, PERTUSSIS, TETANUS or DIPHTHERIA, TETANUS	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	#4 _____ MONTH DAY YEAR	#5 _____ MONTH DAY YEAR	**Tdap** _____ MONTH DAY YEAR

*

*MENINGITIS CONJUGATE (Menactra or Menveo or Medquadfi)

***MCV4** **Must have 1 dose on, or after, age of 16 years old**	_____ MONTH DAY YEAR

*M.M.R. (Measles, Mumps, Rubella)

Two doses of M.M.R. at least 28 days apart after 12 months old. Born before 1957, no immunization required.

M.M.R. (MEASLES, MUMPS, RUBELLA)	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR

IMMUNIZATIONS RECOMMENDED BY WHEATON COLLEGE

POLIO Recommended *Please circle which vaccine given

OPV (oral) *Or* IPV (injected)	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	#4 _____ MONTH DAY YEAR	#5 _____ MONTH DAY YEAR

HEPATITIS B Recommended (Three doses of vaccine OR a positive surface antibody)

HEPATITIS B IMMUNIZATION	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	HEPATITIS B SURFACE ANTIBODY	_____ MONTH DAY YEAR	RESULT: _____REACTIVE _____NON-REACTIVE

VARICELLA (CHICKENPOX) Recommended (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart)

HISTORY OF DISEASE YES_____NO_____OR
DATE_____/_____/_____
MM DD YEAR

VARICELLA ANTIBODY	_____ MONTH DAY YEAR	RESULT: _____REACTIVE _____NON-REACTIVE
IMMUNIZATION	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR

OTHER IMMUNIZATIONS RECEIVED (i.e. Hepatitis A, Typhoid, HPV, Yellow Fever, Meningitis B, Menomune, etc.)

	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	#4 _____ MONTH DAY YEAR	#5 _____ MONTH DAY YEAR
	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	#4 _____ MONTH DAY YEAR	#5 _____ MONTH DAY YEAR

Required Medical Provider Signature_____**Date**_____

Print Name_____**Phone**_____**Fax:**_____

E-mail_____**Address:** _____

Immunization Exemption Policy By Illinois State law, a student may be exempt from immunizations for one of only two reasons: medical or religious. To request an immunization exemption form, please email Student.Health.Services@wheaton.edu. All completed forms will be reviewed by the Director of Student Health Services for approval. This is part of the entrance requirements.

TB SCREENING SUPPLEMENT FOR MEDICAL PROVIDERS

This page should be provided to your medical provider if a new PPD skin test has been administered or an IGRA blood test has been completed based on the information on the TB Screening Questionnaire (page 4). **Student please provide this supplement to your medical provider to complete if they administered/performed one of these tests. If you have prior testing or TB Treatment, please provide the official report(s).**

Patient Name _____/_____/_____
Last First Date of birth Student ID number

TST/PPD Date obtained_____/_____/_____ Date read_____/_____/_____ Month Day Year Month Day Year Results_____Interpretation _____	If positive, refer to CDC.gov rubric. Progress to IGRA testing
Interferon Gamma Release Assay (IGRA) Date obtained_____/_____/_____ (specify method): ϒ QFT ϒ T-Spot Month Day Year Result: negative_____positive_____indeterminate /borderline_____ *Please attach report translated into English.*	If IGRA positive, progress to chest x-ray
Chest X-ray: (Required if IGRA is positive) Date of chest x-ray_____/_____/_____ Result: ϒ normal ϒ abnormal *Please attach report translated into English* Month Day Year	
Medication Section: Were they advised to take medication because of the positiveresults? No_____Yes_____ If yes, did they accept medication? No_____Yes _____ If yes, what medication(s) were prescribed? _____ Date Started:_____/_____/_____Date Ended:_____/_____/_____	

Additional Notes:

1. If BCG was received, an IGRA is preferred to a PPD.
2. If immune deficient, testing may be falsely negative and there is greater risk of progression from LTBI to active disease
3. If a live vaccine was recently received or patient is ill, consider delaying IGRA testing until 4-6 weeks after vaccination or illness to avoid a false positive result.
4. If PPD positive complete IGRA. If IGRA is positive, send chest x-ray results

Health Care Provider

Name _____Signature_____

Address _____

_____

_____Fax_____Phone _____

WHEATON COLLEGE STUDENT HEALTH SERVICES MEDICAL FORMS

MyWheaton.edu email is the official communication of Wheaton College. Please be sure to check your Wheaton College email regularly for updates on your submitted health requirements and other college announcements.				
Form	**Form**	**Form**	**Form**	**Form**
Page 1-2 Medical History	Page 3 Medical Examination	Page 4 Tuberculosis Screening Questionnaire	Page 5 Required Immunizations and Recommended Immunizations	Page 6 Tuberculosis Screening Supplement for Medical Providers* ***If necessary**
Filled out by student* **Complete page two ONLY if student athlete** ***Parent is to fill out Minor Consent if student is a minor on August 1st or later.**	Filled out by M.D., D.O., NP, or PA ***If you are an Intercollegiate Athlete, the Medical Examination must be completed and signed by a MD or DO (or NP in full practice authority states) per NCAA rules and Wheaton College Athletic Department within six months of the start of school year**	Filled out by student	Filled out by Medical Professional with office stamp OR can submit official record of immunizations from office with office stamp	Filled out by Medical Professional with office stamp* *Required only if MD, PA, or NP orders TB Test.

2 easy way to submit your forms securely:	
Preferred Method: **Submit your forms through Northwestern MyChart. All communication will be done through MyChart.** Your MyChart access code will be provided through your my.wheaton.edu email address. **OR** Mail to: Wheaton College, Student Health Services, 501 College Ave, Wheaton, IL 60187, postmarked by your deadline	**Incomplete Student Health Services Requirements:** If health entrance forms are not completed and submitted by the deadline (refer to email from SHS for your deadline), a late fee of $100.00 and/or a registration hold may be placed on the student's account. **Phone: 630.752.5072** **Extension requests for submission of entrance medical requirement forms must be made from student's Wheaton College email 2 weeks before your deadline and are approved at the discretion of the SHS staff.**