



STUDENT HEALTH SERVICE
930 20th Street South, Suite 221
Birmingham, Alabama 35294-2042

Office Use Only:
Duplicate _____
____ Stars ____ Hold
____ Call Clearance ____ P

Full name _____ Student/Social Security No. _____
(Print) Last/Family First MI

The following students **must** complete this form: Medical, Dental, Optometry, Nursing, EMS, Public Health, Health Related Professions (SHRP); Joint Health Sciences and all International Students. Do not leave any blanks. Use N/A for not applicable. Please follow the directions carefully to insure that your form will not be rejected or delayed during processing. **You will not be allowed to matriculate until all 4 pages of this medical record have been completed and received by the Student Health Service at the above address. Incomplete or illegible health forms will not be accepted.** You are to complete pages 1, 2, and 4 entirely; the physician of your choice must complete the physical on page 3, or you may schedule a physical exam at Student Health for a nominal fee. **Do not call to see if we have received your health form.** Please use a return receipt if you desire confirmation. Your department will let you know if there is a problem with your health information. (I encourage you to keep a photocopy of your completed health form and immunization proof for your own records in case these get lost in the mail.)

(please **print** in ink or type)

1. Have you filled out this health application before? Yes ____ No ____
2. Have you ever been seen here at Student Health for an appointment, vaccine, or physical? ____yes____no
3. Are you an International Student? Yes ____ No ____ 4. If yes, what Country _____
5. Sex ____ M ____ F Age _____ 6. Birthdate _____
7. Maiden Name if applicable: _____
8. **What Division of UAB are you entering?** _____ Major: _____ Semester: _____
9. Name of other college previously attended: _____
10. Degree received _____
11. Local address: _____ Phone _____
12. Home address: _____ Phone _____
13. Current email address: (Print Clearly) _____
14. Person to contact in emergency: _____ Phone _____
15. Permanent Address: _____

Health and Accident Insurance

(If you have your own insurance policy you **must** fill out the **Waiver of Medical Center Student's Accident and Sickness Insurance Plan** form to prevent any additional charges to be placed on your student account. This form can be found on our website: www.uab.edu/studenthealth.)

Company _____ Policy Number _____
Address _____ Name of Policy Holder _____

If you have no insurance, you **will** be required to subscribe to the group policy through the Student Health Service.

Medical History

1. Do you have any medical problems? (such as asthma, diabetes, high blood pressure, etc.) Yes ____ No ____ If yes, please explain _____
2. Have you consulted a physician or been hospitalized within the past five years? Yes ____ No ____ If yes, please explain _____
3. Please list any surgery, acute or chronic illnesses, and significant injuries which you have had including dates _____
4. Are you taking any medications regularly at the present time, or have you taken any in the past (including oral contraceptives, antidepressants, allergy injections, etc.)? Yes ____ No ____ If yes, please list _____
5. Are you allergic to any medications or other substances? Yes ____ No ____ If so, list and describe reactions: _____
6. What is your present weight? _____ Your present height? _____ Have you had significant weight loss or gain recently? Yes ____ No ____ Please explain _____
7. Do you eat a balanced diet daily? Yes ____ No ____
8. Do you smoke? Yes ____ No ____ If so, how much, and for how many years? ____ Do you drink alcoholic beverages Yes ____ No ____ If so, type and number of drinks per week _____
Are you concerned about your utilization of alcohol or drugs? Yes ____ No ____

9. Do you have any restrictions on your physical activities? Yes _____ No _____ If yes, please explain _____

10. Is there any other information which would be helpful to the University Student Health Service in providing you with medical care? _____

Do You Have A Present Or Past History Of:

(check each item)

Yes	No		Yes	No			
1.	_____	_____	Eye Problems	20.	_____	_____	Blood Clotting Problems
2.	_____	_____	Ear, Nose or Sinus Problems	21.	_____	_____	Congenital or Birth Defects
3.	_____	_____	Throat/Tonsillar Infections	22.	_____	_____	Cancer or Malignancy
4.	_____	_____	Infectious Mononucleosis	23.	_____	_____	Non-Malignant Tumor
5.	_____	_____	Asthma	24.	_____	_____	Thyroid Disorder
6.	_____	_____	Tuberculosis	25.	_____	_____	Diabetes
7.	_____	_____	Other Lung Infections	26.	_____	_____	Epilepsy or Seizures
8.	_____	_____	Rheumatic Fever	27.	_____	_____	Headaches
9.	_____	_____	Heart Murmur	28.	_____	_____	Depression
10.	_____	_____	Chest Pain	29.	_____	_____	Anxiety or Tendency to Worry
11.	_____	_____	Rapid Heart Beat	30.	_____	_____	Skin Problems
12.	_____	_____	High Blood Pressure	31.	_____	_____	Measles (Red or Rubeola)
13.	_____	_____	Ulcer (Stomach/Duodenal)	32.	_____	_____	Measles (German or Rubella)
14.	_____	_____	Recurrent Diarrhea	33.	_____	_____	Mumps
15.	_____	_____	Colitis/Enteritis	*34.	_____	_____	Chickenpox (If no, vaccine may be required)*
16.	_____	_____	Hepatitis; Type, if known _____	35.	_____	_____	Gynecological Problems
17.	_____	_____	Bladder or Kidney Infection	36.	_____	_____	Herpes/Other Genital Infection
18.	_____	_____	Kidney Stone	37.	_____	_____	Back Problems
19.	_____	_____	Anemia or Blood Disorder	38.	_____	_____	Bone or Joint Problems
				39.	_____	_____	Sports Related Injuries

If any of the above questions are answered yes, please explain _____

*School of Medicine, Nursing, Optometry, Dental and clinical SHRP students require antibody titer testing regardless of past history of chickenpox. Varicella vaccines are required on all clinical students who show a negative titer for chickenpox.

Family History

Are both of your parents living? Yes _____ No _____ Are they in good health? Yes _____ No _____ If no, please explain _____

Numbers of siblings living _____ deceased _____ Cause of Death _____

Is there any history of the following conditions in your family?

Heart Disease	Yes _____	No _____	High Blood Pressure	Yes _____	No _____
Alcoholism	Yes _____	No _____	Psychiatric Disorders	Yes _____	No _____
Diabetes	Yes _____	No _____	Other problems	Yes _____	No _____

STATEMENT AND CONSENT
(Students need to sign this section)

I hereby give to the Medical Center Student Health Service permission to release to the School in which I enroll at the University of Alabama at Birmingham, this and any additional information regarding my health status. I understand this to be used for enrollment purposes only. Further, I give my permission for any diagnostic procedures as may be deemed necessary by the Student Health Service.

X _____
Signature Date Printed Name

I certify that the information given on this form is true and correct, and I have no abnormality, limitation, or restriction not mentioned on this document. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information will constitute sufficient grounds for my dismissal from UAB. I agree to notify the Student Health Service of any change in my physical or mental health either prior to my registration or while I am a student at The University of Alabama at Birmingham, Medical Center. I acknowledge by my signature that I have read and understand these statements.

X _____
Signature Date

You may schedule a physical exam at Student Health if you do not have a physician. Call 205-934-3581 and ask our receptionist for details.

TO THE PHYSICIAN: This medical information is confidential and remains in the Student Health Service. It is necessary for our medical care and advice regarding programs of study and medical clearance for enrollment. Please review medical history with student. Supplemental details are needed if any positive answers are given to questions 1-39 on page 2. Check normal or abnormal on physical exam and leave blank if not done.

Name _____ Social Security Number _____

Height _____ in. Weight _____ lbs. Temp. _____ F. Pulse _____ BP _____

Vision: O.D. _____ \ O.S. _____ \ O.U. _____ \ With Correction: _____ yes _____ no

(Wearers of contact lenses are advised to have a pair of glasses for alternative use.)

Ears: Is hearing normal? Yes _____ No _____ Are drums intact? Yes _____ No _____

Color Vision Screening (for medical students only please) Result _____ Date _____

	Normal	Abnormal		Normal	Abnormal
Skin			Abdomen		
Head, Face, Neck			Endocrine System		
Nose and Sinuses			Spine		
Mouth and Throat			Neurologic		
Teeth			Hernia		
Lungs and Chest			Genitalia		
Heart			Breasts		
Vascular System			Pelvic, if indicated		

Are muscle strength and function of extremities normal and all digits present? Yes _____ No _____

Comments: _____

Physician's Name: (Print) _____

Month/Day/Year

Physician's Signature: _____ M.D./D.O./N.P. Date _____

(Physician must sign to get credit for this physical exam.)

Office Phone _____

Office Email _____

Office Stamp or Address _____

NAME: _____ Student/Social Security No. _____
(Print) Last/Family First MI

IMMUNIZATION HISTORY

READ CAREFULLY:

You must fill this page out legibly and attach photocopy documentation of your immunizations to the back of this form. If you cannot find documented proof such as medical records, or certificates of immunizations, then you will be required to retake or titer test the undocumented immunization before you can matriculate. All students participating in the UAB Student Health Service are required to have a Tuberculin Skin Test and be immunized against Tetanus, Diphtheria, Rubella and Mumps within the time requirement noted below. All other immunizations are required unless exempted by the school to which you are enrolling. **Do NOT estimate your immunization dates.** (Undocumented immunization data will not be entered into our system, and you will have to retake or titer test before you are cleared.)

TUBERCULIN SKIN TESTING: We will only accept TB testing done in the United States. (International students must take a one-step TB test within three months prior to enrollment and regardless of prior BCG vaccination). Domestic students should have their testing within a year of their matriculation date. **Two Step TB testing required for all medical/health related students only.** (Two step TB testing requires 2 TB tests taken no less than one week apart and no longer than one month apart from each other.) **Note:** Only individuals with a past positive (10mm or more result) will need to provide us with a current chest x-ray. We will not accept a chest x-ray report in lieu of your TB test requirement.

1 Step TB Test: _____ Date _____ 2 Step TB Test: _____ Date _____

Results: ___ Positive* (Record reaction in mm) _____ mm Results: ___ Positive* (Record reaction in mm) _____ mm
 ___ Negative _____ Negative

Additional Annual 1 Step (For office use only): _____

***If reaction positive, or has been positive in the past, current (within past 3 months) Chest X-Ray Report is required:**
 CXR Date: _____ Results: _____

UAB requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (Rubeola, MR, MMR) prior to registration. One dose must have been after 1980 and at least one of the doses must have been an MMR. (In lieu of vaccines serological proof of immunity will be accepted.)

	Date Last Received Month/Day/Year	
MMR (Rubeola, Rubella, Mumps) — primary** (Must have been given after 1 year of your birth)	1. _____	2. _____
MMR (Rubeola, Rubella, Mumps) — booster Rubeola (Red Measles) if given separately	1. _____	2. _____
<Rubeola Serologic proof of immunity	1. _____	2. _____
Rubella*** if given separately	1. _____	2. _____
< Rubella Serologic proof of immunity	1. _____	2. _____
Mumps if given separately	1. _____	2. _____
<Mumps Serologic proof of immunity	1. _____	2. _____
DT booster (Diphtheria/Tetanus) (Required within last 10 years)	1. _____	2. _____
Polio Completed:	1. _____	2. _____
Varicella (Chickenpox) Proof of two vaccines	1. _____	2. _____
Varicella Antibody titer (required for all clinical students)	Pos. _____	Neg. _____
Please attach a copy of you varicella labsheet to this health form.		
Meningococcal Vaccine (<i>strongly encouraged but not mandatory yet</i>)	_____	

**Exempt if born prior to 1957

***School of Nursing requires Rubella titer if never immunized.

DOCUMENTATION OF HEPATITIS TYPE B IMMUNIZATION (Usually required for medical/health related students only)

	Month/Day/Year	Where Received
Dose #1	_____	_____
Dose #2	_____	_____
Dose #3	_____	_____
Booster	_____	_____

Antibody titer required 1-2 months after the last dose of vaccine.

HEPATITIS TYPE B SURFACE ANTIBODY TITER (HBSAB) REQUIRED ON ALL MEDICAL/HEALTH-RELATED STUDENTS WHO HAVE COMPLETED THEIR VACCINE SERIES.

(Please attach a copy of your HBSAB Labsheet to this health form.)

	Date Drawn Month/Day/Year	Where Drawn
HBSAB Titer _____ Level _____ <small>(Pos/Neg)</small>	_____	_____
Retest HBSAB _____ Level _____ <small>(Pos/Neg)</small>	_____	_____

IF PAST HISTORY OF TYPE B HEPATITIS DISEASE:

	Date Drawn Month/Day/Year	Where Drawn
Type B Surface Antigen Titer _____ Level _____ <small>(Pos/Neg)</small>	_____	_____
Type B Surface Antibody Titer _____ Level _____ <small>(Pos/Neg)</small>	_____	_____

Forms are processed in the order that they arrive in our office. We encourage you to turn these forms in completely filled out with all the necessary immunization documentations attached at least 2 weeks before your program's deadline date. Do not expect miracle clearances if you turn in incomplete or late applications. Calling our office to check about your clearance status only slows down our ability to process everyone's health forms on time. Your program will let you know if there is additional information needed.

You must fill this page out in order to process your paper work efficiently