SOKA UNIVERSITY OF AMERICA
ALISO VIEJO

STUDENT HEALTH HISTORY

Dear Student:

Welcome to Soka University of America. The Student Health Center provides medical services that you may need. Please read the form carefully, fill out as completely as possible and return it by **July 1st** to Student Affairs at:

Soka University of America ▪ Attn: Student Affairs ▪ 1 University Drive ▪ Aliso Viejo, CA 92656-4105

PERSONAL DATA

To the Student:

The information reported here will be kept confidential and be part of your health record maintained in Student Affairs and the Student Health Center. It may not be released without your written consent or a court order. Completion of this form will enable Student Health Center staff to evaluate your present and past health history and to efficiently diagnose and provide treatment should you require medical care. Staff members may share information you provide for purposes of your medical care and consultation. Your signature below indicates consent to receive treatment under these conditions:

PLEASE PRINT

LAST NAME / FIRST NAME / MIDDLE	SEX	BIRTHDATE (Month/Day/Year)	MARITAL STATUS	SOCIAL SECURITY #

HOME ADDRESS	CITY/STATE OR PROVINCE/ZIP CODE/COUNTRY	PHONE NUMBER
		( )

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY	RELATIONSHIP	PHONE NUMBER
		( )

ADDRESS	CITY/STATE OR PROVINCE/ZIP CODE/COUNTRY

NAME OF PERSONAL PHYSICIAN	PHONE NUMBER
	( )

ADDRESS	CITY/STATE OR PROVINCE/ZIP CODE/COUNTRY

PERMISSION FOR TREATMENT AND RELEASE OF INFORMATION

In case of routine health examinations, immunizations, diagnostic procedures, treatment of illnesses and/or injuries, permission is hereby granted to treat the student named, herein, at the Soka University of America Student Health Center in partnership with South Coast Medical Group, and to make necessary referrals for emergency transport, or to private physicians, specialists, psychologists, counselors, and/or other local community facilities as his/her condition may dictate.

X _____ / /

SIGNATURE OF STUDENT | AGE | TODAY'S DATE (Month/Day/Year)

If student is under 18 years of age, signature of parent or legal guardian is required below:

X _____ / /

SIGNATURE OF PARENT OR LEGAL GUARDIAN | PRINT NAME | TODAY'S DATE (Month/Day/Year)

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STUDENT HEALTH HISTORY

HEALTH QUESTIONNAIRE

Name: _____ **Birthdate:** _____

DRUG ALLERGIES

FOOD ALLERGIES

CURRENT MEDICATIONS

FAMILY HISTORY
Please check off who in your family has had the following medical conditions

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Self
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsion						
Bleeding disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

HOSPITALIZATION (include psychiatric hospitalization) OR SURGERY

Reason	Date	Reason	Date

MEDICAL CONDITIONS (including personal counseling or psychotherapy) AND/OR DISABILITY REQUIRING CARE/ACCOMODATIONS

PAST MEDICAL HISTORY
Please check off the medical conditions you currently have or have had in the past

- ❒ Migraines
- ❒ Rheumatic Fever
- ❒ High blood pressure
- ❒ Heart Arrhythmia
- ❒ Heart murmur
- ❒ Heart Attack
- ❒ High Cholesterol
- ❒ Peripheral vascular disease
- ❒ Allergies/Hay fever
- ❒ Asthma
- ❒ Bronchitis
- ❒ Pneumonia
- ❒ GI disorder
- ❒ Lactose Intolerance
- ❒ Gall bladder disease
- ❒ Prostate disease
- ❒ Incontinence
- ❒ Sexual/Menstrual dysfunction
- ❒ Sexually Transmitted Disease
- ❒ Hepatitis
- ❒ Anemia
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Gout
- ❒ Schizophrenia
- ❒ Severe Depression
- ❒ Suicide
- ❒ Thyroid disease
- ❒ Diabetes Type I ❒ Type II ❒
- ❒ Last A1C blood test_____
- ❒ Chronic rashes
- ❒ Cancer_____type
- ❒ Sleep Apnea
- ❒ A.D.D.
- ❒ Other_____

HABITS

❒ Smoke: Packs daily	*How long?*	*When stopped?*
❒ Coffee: Cups daily?	*Other caffeines?*	Diet: Salt intake
❒ Exercise routine:		Fat intake
❒ Alcohol: Type/Amount		

❒ SLEEP: Difficulty falling asleep ❒ Snoring ❒ Daytime drowsiness ❒ Continuity disturbances ❒ Early morning awakening

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STUDENT HEALTH HISTORY

Student Name (Please Print): _____ **Birthdate**: _____

IMMUNIZATION (VACCINE) RECORD

To be filled out by a licensed HEALTHCARE PROVIDER (MD, PA, or NP)

Include copies of applicable immunization/vaccine records, lab test results and forms.

MANDATORY IMMUNIZATIONS

MMR (Measles, Mumps, Rubella):
2 Doses (live measles virus) OR; doctor documented history of measles, mumps, rubella diseases WITH proven immunity by serologic testing - lab copy must be submitted.

DATE Dose 1 (Month/Day/Year) Given on or after 12 months of age

DATE Dose 2 (Month/Day/Year) Given at least 28 days after dose #1 and after 1980

If applicable additional MMR Information:

Tdap (Tetanus/Diphtheria/Pertussis):
Must be within the past 10 years

DATE (Month/Day/Year)

DATE (Month/Day/Year)

Meningitis Vaccine:
1 Dose needed if first time.
2nd Dose needed if received 1st dose before 16 years old.

DATE Dose 1 (Month/Day/Year)

DATE Dose 2 (Month/Day/Year)

Hepatitis A:
2 Doses

DATE Dose 1 (Month/Day/Year)

DATE Dose 2 (Month/Day/Year)

Hepatitis B:
3 Doses required

DATE Dose 1 (Month/Day/Year)

DATE Dose 2 (Month/Day/Year)

DATE Dose 3 (Month/Day/Year)

Tuberculosis Testing (TB skin test)
Current within 12 months – TB skin test and result must be documented. *If TB is positive, chest x-ray is required

DATE (Month/Day/Year)

Result/Reaction:
☐ Negative ☐ Positive _____mm/induration

**Chest X-Ray*
Current within 12 months

DATE (Month/Day/Year)

Result:
☐ Normal ☐ Abnormal

HIGHLY RECOMMENDED IMMUNIZATIONS

Polio Vaccine (Injectable or Oral):
3 Doses

DATE Dose 1 (Month/Day/Year)

DATE Dose 2 (Month/Day/Year)

DATE Dose 3 (Month/Day/Year)

HPV (Human Papillomavirus: Vaccine):
3 Doses

DATE Dose 1 (Month/Day/Year)

DATE Dose 2 (Month/Day/Year)

DATE Dose 3 (Month/Day/Year)

Varicella (Chicken pox):
If NO history of disease, 2 doses of Varivax required.
If you have had Chicken pox, provide date of disease

DATE Dose 1 (Month/Day/Year)

DATE Dose 2 (Month/Day/Year)

OR

Disease DATE(Month/Day/Year)

HEALTHCARE PROVIDER INFO & SIGNATURE

Healthcare provider's name (please print): _____ Phone number: _____

Address: _____
Street City State Zipcode Country

Medical provider signature: _____ MD / PA / NP Date: _____