University of Pittsburgh at Bradford
MANDATORY
STUDENT HEALTH EVALUATION FORM

PLEASE RETURN COMPLETED FORM TO:
University of Pittsburgh at Bradford
Student Health Services
300 Campus Drive
Bradford, PA 16701-2898
Phone: (814) 362-5272
Fax: (814) 362-7514

Today's Date:____________________

Commuter______ Resident______
Part-Time ______ Full-Time_____

Please Print or Type **No Physician's Physical Required**

Last Name	First	Middle	Last 4 Digits of Social Security #

Home Address: Street	City	State	Zip

Phone: Area Code and No.	Student Cell Phone Number

Age	Birthdate (Month, Day, Year)	Sex	Marital Status	Are you a Veteran? ☐ Yes ☐ No

INSURANCE INFORMATION:

1. Are you covered by health insurance? ( ) yes ( ) no
   ( ) Coverage through parent or family policy
   ( ) Individual policy holder

2. Please complete the information below or attach photocopy of insurance card (front and back)

   NAME OF INSURANCE COMPANY ____

   Address of insurance company ____

   City ____________________________ State ________ Zip ______________ Phone ____________________

   POLICY HOLDER'S NAME _____________________________ Relationship __________________________

   Policy holder's date of birth _________________ and Social Security Number ____________________________

   Telephone _________________________ Place of employment _______________________________________

   POLICY IDENTIFICATION NUMBERS:

   Agreement number _____________________________ Group number ________________________________

   Plan Code ____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Last Name	First	Middle	Relationship	Phone: Area Code & No. Home: Work or Cell:

Street Address	City	State	Zip

PERSONAL HEALTH HISTORY

Have you had or do you now have any of the following:

	NO	YES	
1.	( )	( )	Vision difficulty, eye problems
2.	( )	( )	Ear trouble/hearing difficulty
3.	( )	( )	Sinus trouble
4.	( )	( )	Broken nose
5.	( )	( )	Repeated tonsil infections
6.	( )	( )	Thyroid problems
7.	( )	( )	Abscessed tooth
8.	( )	( )	Gum disease
9.	( )	( )	Pneumonia
10.	( )	( )	Asthma
11.	( )	( )	Chronic bronchitis
12.	( )	( )	Emphysema
13.	( )	( )	Heart problems
14.	( )	( )	Heart murmur
15.	( )	( )	Rheumatic heart disease
16.	( )	( )	Coronary artery disease
17.	( )	( )	High blood pressure
18.	( )	( )	Stroke
19.	( )	( )	Blood clotting disease
20.	( )	( )	Anemia
21.	( )	( )	Diabetes
22.	( )	( )	Digestive disorder
23.	( )	( )	Stomach ulcer
24.	( )	( )	Chronic diarrhea
25.	( )	( )	Ulcerative colitis
26.	( )	( )	Liver problem, hepatitis
27.	( )	( )	Kidney problems
28.	( )	( )	Bladder infection
29.	( )	( )	Pelvic infection
30.	( )	( )	Disabling menstrual period
31.	( )	( )	Irregular menstrual period
32.	( )	( )	Hernia
33.	( )	( )	Pilonidal sinus/cyst
34.	( )	( )	Skin problems
35.	( )	( )	Eczema
36.	( )	( )	Gout
37.	( )	( )	Cancer
38.	( )	( )	Arthritis
39.	( )	( )	Broken bones
40.	( )	( )	Sprains
41.	( )	( )	Dislocations
42.	( )	( )	Concussion
43.	( )	( )	Back problems
44.	( )	( )	Fainting episodes
45.	( )	( )	Seizure disorder
46.	( )	( )	Migraine headaches
47.	( )	( )	Alcohol Abuse
48.	( )	( )	Drug Abuse
49.	( )	( )	Depression
50.	( )	( )	Anxiety
51.	( )	( )	Eating Disorder
52.	( )	( )	Attention Deficit Disorder
53.	( )	( )	Other Psychological Disorder

Do you have ALLERGIES to any of the following:

NO YES

54. ( ) ( ) Medications - Please list name of medications and type of reaction:

____

55. ( ) ( ) Inhalants: Circle which ones:
pollen ragweed grasses
dust mold smoke

56. ( ) ( ) Food allergies - Please list:

____

57. ( ) ( ) Chemicals or contact substances:

____

58. ( ) ( ) Others - Please list:

____

NO YES

59. ( ) ( ) Are you currently taking any prescribed medication on a regular or intermittent basis?

Name of medication: Condition for which it is prescribed:

____

____

60. ( ) ( ) Have you ever been hospitalized for an illness or injury?

Date/Year Reason for hospitalization:

____

61. ( ) ( ) Do you have any chronic health problems which require regular treatment?

62. ( ) ( ) Do you have a physical handicap or a learning disability with which we can assist you?
(*If yes, contact Disability Resources and Services at 814-362-7533.)

Please give significant explanations of *all* of the above items to which you have answered YES. Refer to items by number.

____

____

____

IMMUNIZATION REQUIREMENTS

Immunization requirements for **all full-time college students born after 1956** are as follows:
Records indicating proof of the immunizations listed below must be submitted with this health form.
Attach photocopy of signed or stamped physician/clinic records and/or school immunization certificate listing dates of immunizations.

MANDATORY

Measles/Mumps/Rubella (MMR) – TWO DOSES REQUIRED

Dose #1 given at age 12-15 months or later.
Dose #2 given at age 4-6 years or later, and at least one month after first dose.
NOTE: If you are unable to obtain these records, ONE CURRENT MMR vaccine received within the past three years satisfies the immunization requirements. Written proof from the clinic or physician must be attached to this health form.

ADDITIONAL REQUIREMENTS FOR STUDENTS LIVING IN CAMPUS HOUSING:

* ONE dose of meningococcal conjugate vaccine (MCV4), also known as Menveo or Menactra, administered ***at age 16 or older.***

- OR -

A signed waiver form declining the meningococcal conjugate vaccine (MCV4)
The opportunity to sign a waiver is available as part of the online Housing Application.
** Failure to show proof of all required immunizations will result in a HOLD on next semester's registration.**

COMMUNICABLE DISEASE HISTORY

Please indicate if you have had any of the following diseases and at what age you had the disease.

NO	UNCERTAIN	YES	AGE	
( )	( )	( )	_____	Measles (9 days)
( )	( )	( )	_____	German Measles (Rubella 3 days)
( )	( )	( )	_____	Mumps
( )	( )	( )	_____	Chickenpox
( )	( )	( )	_____	Whooping Cough
( )	( )	( )	_____	Diphtheria
( )	( )	( )	_____	Polio
( )	( )	( )	_____	Tuberculosis
( )	( )	( )	_____	Rheumatic Fever
( )	( )	( )	_____	Mononucleosis

FAMILY HEALTH HISTORY

Please indicate if any of your blood relatives (parents, brothers, sisters, children, grandparents) have had any of the following:

	NO	YES	RELATIONSHIP
Diabetes (take Insulin)	( )	( )	_______________
Diabetes (takes pills for it)	( )	( )	_______________
Epilepsy	( )	( )	_______________
High Blood pressure	( )	( )	_______________
Heart Attack	( )	( )	_______________
Heart Disease	( )	( )	_______________
Stroke	( )	( )	_______________
Asthma	( )	( )	_______________
Thyroid problem	( )	( )	_______________
Arthritis	( )	( )	_______________
Gout	( )	( )	_______________
Obesity	( )	( )	_______________
Alcohol or Drug Problem	( )	( )	_______________
Breast cancer	( )	( )	_______________
Other Cancer	( )	( )	_______________
Allergies	( )	( )	_______________
Anxiety, Depression or other mental disorder	( )	( )	_______________

To be completed by student

SELF EVALUATION OF LIFESTYLE FACTORS

1. EXERCISE: How many times per week do you spend at least 30 minutes in vigorous physical exercise such as biking, running, swimming? ____________________

2. BODY BASICS: What is your height? ____________
   What is your body weight? ____________
   Do you consider yourself:
   ( ) underweight ( ) overweight
   By how many pounds? ____________

   Have you ever been told you had high blood pressure? ________ (You can get your blood pressure checked in Health Services Room 226 in the Commons Building M-F 8:30am to 5:00pm, Fall & Spring semesters.)

3. NUTRITION: Do you eat a balanced diet, including whole grain breads and cereals, fruits, vegetables, protein and carbohydrates?

   ____

   Do you try to limit your intake of butter, fried foods and dairy products which are high in fat and/or cholesterol?

   ____

4. TOBACCO USE: Do you smoke cigarettes? ____________
   How many per day? ____________
   How long have you been a smoker? ____________
   Do you chew tobacco? ____________
   Are you interested in quitting? ____________
   (Counseling is available in Health Services to quit tobacco.)

5. ALCOHOL USE: How often do you drink alcohol?
   ( ) not at all
   ( ) less than once a week
   ( ) once a week
   ( ) 2 or 3 times per week
   ( ) more than 3 times per week

   What is your average alcohol consumption (number of shots, 8 oz. beers or 6 oz. glasses of wine) per drinking occasion? ____________

   Do you think you have a problem with alcohol?
   ____
   (Counseling is available in Counseling Services Rm. 226.)

RELEASE OF INFORMATION

I hereby grant permission to the Student Health Service of the University of Pittsburgh at Bradford to release the information on this Student Health Evaluation Form to Campus Police personnel, Residence Life staff, Counseling Services, Ambulance personnel, and/or Bradford Regional Medical Center Emergency Department personnel if needed, and in the best interest of my health and safety.

____________________ Student's Signature   ____________ Date

____________________ Parent's Signature IF student is under 18 years of age   ____________ Date