TUBERCULOSIS TEST: It is recommended that all students provide evidence of either a recent skin test or chest x-ray.

TB Skin Test (Mo/Yr) IF POSITIVE: Chest x-ray (Mo/Yr) MEDICATION TAKEN:

Result: ☐ Neg ☐ Pos Result: DATE STARTED: DATE FINISHED:

TETANUS Date of last immunization: **HEPATITIS B** Have you completed the series of 3? ☐ Yes ☐ No

FAMILY HISTORY Any parent, grandparent, or sibling with the following:

	Which Family Member (s)		Which Family Member (s)
☐ anemia/blood disorder			
☐ anxiety disorder		☐ neurological disorder	
☐ arthritis		☐ other mental illness	
☐ asthma/allergies		☐ stroke	
☐ cancer		☐ suicide	
☐ clotting disorder		☐ thyroid disorder	
☐ depression		☐ ulcers	
☐ diabetes			
☐ heart disease		☐ other	
☐ high blood pressure			

HABITS AND SOCIAL ISSUES

What is your current height? _____ current weight? _____

Do you have concerns about your current weight? ☐ Yes ☐ No
Concerns _____

Do you have concerns about your current diet and exercise habits? ☐ Yes ☐ No
Concerns _____

Do you use tobacco? ☐ Yes ☐ No
If yes, amount/day _____ #years of use _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, estimated days per month you drink _____
How often do you drink 4 or more drinks on one occasion? _____

Do you use recreational drugs? ☐ Yes ☐ No
If yes, which ones? _____

Are you sexually active? ☐ Yes ☐ No ☐ Yes, in the past, but not currently

If yes,
Have your partners been: ☐ Male ☐ Female

What method of contraception are you using? ☐ None ☐ Don't need
_____

Do you use protection against STD's? ☐ Always ☐ Sometimes ☐ Never ☐ N/A

STAFF NOTES

☐ Health ed provided

☐ Referral

☐ F/U appt. advised

RN initial	DATE

PLEASE DISCUSS WITH YOUR PROVIDER IF YOU ARE CURRENTLY IN A RELATIONSHIP WHERE YOU ARE BEING PHYSICALLY HURT (SUCH AS HIT, KICKED, OR PUNCHED) OR ARE FEARFUL FOR YOUR SAFETY.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE.

DATE _____ STUDENT SIGNATURE _____