University Health Services

(678)466-4940

Health Assessment/History

Student ID________________________ Date of Birth______/______/______ Age_______ Gender: M_____F_____

Last Name________________________ First Name________________________ MI/Maiden Name_________________

Street Address_________________________________ City____________________ State______ Zip Code______________

Home Phone________________________ Work Phone________________________ Cell Phone_______________________

School Email____ Drug Allergies_____________________________________

Emergency Contact Name: ____ Phone Number___________________________

FAMILY HISTORY Adopted *

Provide if anyone in your family (parents, grandparents, or siblings) has had any of the following; if so, list on the lines below.

No	Yes		No	Yes	
*	*	Breast Cancer____________________	*	*	Strokes/Blood clot_____________________
*	*	Cancer________________________	*	*	High Cholesterol_______________________
*	*	Diabetes________________________	*	*	High Blood Pressure_____________________
*	*	Heart attack before 50___________________________	*	*	Birth Defects / Genetic Problems or traits_______________________
*	*	Congestive Heart Failure_______________________			

PERSONAL HISTORY: Have you ever had the following: if you check yes, please circle any appropriate responses.

No	Yes		No	Yes	
*	*	High Blood Pressure	*	*	Surgery? Type: _______________________
*	*	Diabetes	*	*	Hospitalization? Dates:_____________________________ Types:_____________________________
*	*	Cancer			
*	*	Headaches: Tension/stress, migraines, sinus/allergy	*	*	Breast (lumps, tumors, discharge, cysts)
*	*	Epilepsy, convulsions, fainting			
*	*	Thyroid disease	*	*	Vaginal/Penile Infections (BV, PID, Yeast, Gonorrhea, Syphilis, Genital Warts, Genital Herpes, Chlamydia, other)
*	*	Excess hair			
*	*	Acne			
*	*	TB, Asthma			
*	*	Heart disease/murmur/Rheumatic fever	*	*	Fibroids, Tubal pregnancy
*	*	Strokes/Blood clots	*	*	Last Pap / Pelvic exam?__________________
*	*	Anemia, clotting problems, Sickle cell	*	*	Abnormal Pap(s):________________________ Date(s) done:________________________
*	*	High Cholesterol			
*	*	Hepatitis, Mononucleosis, Jaundice	*	*	Treatment for abnormal pap:________________
*	*	Gall bladder disease	*	*	Pain or bleeding w/ intercourse
*	*	Stomach or intestinal problems	*	*	Are you concerned about your weight/eating habits?
*	*	Urinary or bladder infections / Kidney problems			
			*	*	Anxiety, depression, anorexia, bulimia
*	*	HIV			
*	*	Hernia	*	*	Do you participate in a regular exercise program? ________________________
*	*	Vision Problems/Color Blindness			
*	*	Hearing Problems	*	*	Tobacco use? How much / day?_______________
*	*	Joint Problems / Arthritis	*	*	Alcohol use? How much / day?_______________
			*	*	Recreational drugs? How much / day?___________

There will be a $5.00 'No-Show' fee charged if appointment is not rescheduled or canceled 4 hours prior to appointment time.

___________________________________ ___________________________________

Patient Signature Date

University Health Services
2000 Clayton State Boulevard
Morrow, Georgia 30260 (678)-466-4940

Consent and Release Form

I understand that there are always significant risks, which can include, but are not limited to physical injury, danger of reaction to vaccine, and even death, with any medical test, vaccine or procedure. I, ______________________ am presenting myself for treatment at the Clayton State University Health Services (UHS). I voluntarily consent to the rendering of medical, nursing and emergency care, including but not limited to diagnostic procedures, medical treatment and any other procedures by employees/agents of UHS, as in their professional judgment to be deemed necessary or beneficial. I understand that the practice of medicine and nursing is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations or treatment of my condition. I certify that I have read the foregoing, and I am the patient, or I am authorized to consent on behalf of the patient.

Vaccines

Are you sick now with something more serious than a cold? *Yes *No
Have you had a serious reaction to any vaccine before? *Yes *No
Are you taking a drug or undergoing treatment or have a condition that lowers the body's resistance to infection, such as cortisone, prednisone, certain anticancer drugs, or radiation? *Yes *No
Are you allergic or sensitive to any other component of a vaccine? *Yes *No
Are you allergic to latex rubber? *Yes *No
Are you pregnant? *Yes *No
Do you have any immune-compromising conditions (excluding HIV)? *Yes *No
Are you HIV (human immunodeficiency virus) positive? *Yes *No

I do hereby consent to and authorize Clayton State University's University Health Services representative to administer the______________________ vaccine injection to me. I have been given and read the VIS (Vaccine Information Statement). I have had a chance to ask questions that were answered to my satisfaction. I believe and understand the benefits and risks of the vaccine listed above be given to me or to the person named below for whom I am authorized. I agree to release Clayton State University, UHS, and all their agents, should an unforeseen or untoward event occur as a result of this injection or its failure to prevent immunity. I understand that I may have fever, soreness, and/or redness at the injection site.

Receipt of notice of privacy practices written acknowledgement form:

Last Name	First Name	MI	Student ID#
Street Address	City	State	Zip
Date of Birth Age	County	Phone Number ( ) -	

I have received a copy of Clayton State University's UHS Notice of Privacy Practices.

Information about person to receive treatment, vaccine, and acknowledgement of all the above: (Please print)

Signature of person consenting to treatment, receive vaccine or person authorized to make the request (parent or legal guardian).

X____ **Date**_________________________

The above consent given on the patient's behalf for services listed above, because the patient is a *minor of 17 years or younger* or is unable to consent for him/herself. **Name:** _____________________________**Relationship to the patient**:____________________

There will be a $5.00 'No Show' fee charge if appointment is not rescheduled or canceled 4 hours prior to appointment time.

____
Witness