WHEATON COLLEGE STUDENT HEALTH SERVICES
MEDICAL HISTORY REPORT

SEE LAST PAGE FOR INSTRUCTIONS. To be completed by Wheaton College Student; all information must be in English.

Name:_____ ID# _____
Last name First name MI Preferred name

Address:_____
Street City State Zip Student's cell phone

Date of Entry:____/____ Date of Birth:____/____/____ Sex: ☐M ☐F _____
Mo Yr Mo Day Yr Maiden Name

Status: ☐Part-time ☐ Full-time ☐ Graduate ☐Undergraduate ☐Consortium ☐Modular ☐ELIC ☐Spouse of student ☐Employee

Campus: ☐Wheaton College ☐HoneyRock/Northwoods ☐Science Station Black Hills ☐Study Abroad Program

Have you previously attended Wheaton College? ☐Yes ☐ No If yes, last yearof attendance_____Maiden Name _____

In case of Emergency Notify:_____
(Minors must fill this out with guardian in the USA) Name Address Relationship to student

_____
Home Phone (with area code) Cell Phone (with area code) Work Phone (with area code)

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death	Immediate Family Medical History	Yes	No	Relationship
Father						Autoimmune disease			
Mother						Cancer			
Siblings						Diabetes			
						Heart Disease			
						Kidney Disease			
						Seizures			
Spouse						Stroke			
Children						Tuberculosis			
						Psychiatric/mental health disease			
						Family history of sudden death before age 50 (cause unknown)			

PERSONAL HISTORY: Please comment on all yes answers in comment section or on an additional sheet.

Have You Had?	**Y**	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
ADD/ADHD			Depression/Anxiety			Malaria			Sinus condition		
Anemia			Diabetes			Menstrual problems			Sleep Disturbance		
Asperger Syndrome			Disordered Eating			Mononucleosis			Stomach Disorder		
Asthma			Eye problem			Orthopaedic			Strep throat, recurrent		
Back Problem			Gallbladder disease			Pneumonia			Surgery		
Bipolar Disorder			Head injury			POTS			Appendectomy		
Bronchitis, recurrent			Headache, recurrent			PTSD			Tonsillectomy		
Cancer			Heart condition/Murmur			Recent International Travel			Other		
Celiac Disease			Hepatitis			Recurrent Concussions			Thyroid disorder		
Chickenpox			High Blood Pressure			Seizures			Tuberculosis		
Counseling			HIV/AIDS			Self Harm			Urinary tract infection		
Crohn's/Ulcerative Colitis			Kidney disorder			Sexually transmitted disease			Weight gain/loss, recent		

COMMENTS: _____

_____

_____

HOSPITALIZATIONS/SURGERY: ☐ None
Reason(s)_____Date(s)_____

List allergies to medications, foods, pollen, molds, other: ☐ None_____

List medications/herbals taken regularly:☐ None_____

List accessibility needs: _____

Other: _____

Student's Signature (Required)_____ **Date**_____

PARENTAL CONSENT: If your student is <18 years of age, please complete the Consent for Minors, found on the SHS website

Wheaton College

Complete Only If New Intercollegiate Athlete

Athletics Medical History

Name:_____Sport(s):_____ID#: _____

DOB:_____Sex:_____Cell Phone:_____Age:_____Year: _____

FEMALES ONLY:

1. Have you ever had a period? Yes/No Age of Onset?
2. How many periods have you had in the past year? ____
3. Interval between periods? _____ Duration of periods? ____
4. Are you on medication for your periods? Yes/No
   If "Yes" name of medication: _____
5. Have you gained or lost more then 10 lbs. in the past year?
6. Are you happy with your weight? Yes/No
   Explain: _____
7. Are you trying to gain or lose weight? Yes/No
8. Has anyone recommended you change your weight or diet? Yes/No
9. Do you limit or carefully control what you eat? Yes/No

CARDIOLOGY QUESTIONS:

10. Have you ever had discomfort, pain, or pressure in your chest during exercise?	Yes/No
11. Does your heart race or skip beats during exercise?	Yes/No
12. Have you ever fainted or passed out during or after exercise?	Yes/No
13. Has a doctor ever ordered a test for your heart? (i.e. EKG, echocardiogram)	Yes/No
14. Has a doctor ever told you that you have:	
High Blood Pressure	Yes/No
High Cholesterol	Yes/No
Heart Murmur	Yes/No
Heart Infection	Yes/No
Abnormal Heart Beat	Yes/No
Sickle Cell Disease	Yes/No
15. Do you have a family history of the following:	
Sudden Death	Yes/No
Death under age 50	Yes/No
Heart Disease	Yes/No
Heart Attack	Yes/No
Passing out/Syncope	Yes/No
Sickle Cell Disease	Yes/No
High Blood Pressure	Yes/No
Marfan's Syndrome	Yes/No

Explain "Yes" answers here (Please number the answer.):

NEUROLOGICAL QUESTIONS:

16. Have you ever experienced any of the following:	
"Burner" or "Stinger"	Yes/No
Head injury or concussion/ How Many? _____	Yes/No
"Blacked out"/"Knocked out"	Yes/No
Confusion or memory loss due to hit to head	Yes/No
Seizures/Epilepsy	Yes/No
Hospitalization due to a concussion or mild traumatic brain injury	Yes/No
Headaches with exercise	Yes/No
Numbness, tingling, or weakness in your arms or legs after falling or being hit	Yes/No
Inability to move a limb due to a hit or a fall	Yes/No

ORTHOPEDIC QUESTIONS:

17. Have you ever had an injury, illness, or surgery (i.e. sprain, strain, tendonitis, fracture, stress fracture, dislocation, etc.) that caused you to miss a practice or game?	Yes/No
18. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	Yes/No
19. Have you had any fractures or stress fractures in the past two years?	Yes/No

Circle the following body part(s) that apply to the above three questions:

Head	Hand	Wrist	Neck	Chest
Lower Leg	Back	Hip	Ankle	Shoulder
Thigh	Foot/Toes	Arm	Elbow	Knee

Other Organs:

20. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Yes/No

GENERAL MEDICAL

21. Has a doctor ever denied or restricted your participation in sports for any reason?	Yes/No
22. Do you have or have you had any of the following? If "Yes" please circle.	Yes/No

Cancer	Asthma	Chicken Pox	Diabetes	Heat Illness
Hepatitis	Hernia	Pneumonia	Ulcers	Measles
Mono	High/Low Blood Sugar		Birth Deformities	
Rheumatic Fever		Kidney Disease		Tuberculosis
Shortness of Breathe		Hospitalization		Surgery

23. Are you currently taking any prescription or non-prescription (over-the-counter) medications?	Yes/No
24. Do you have allergies to medicines, pollens, foods, or stinging insects?	Yes/No
25. Are you taking supplements?	Yes/No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes/No
27. Do you or a family member have a history of asthma or exercise induced bronchospasms?	Yes/No
28. Were you born without, missing, or have lost function of an organ (ovary, kidney, eye, testicle, etc.)?	Yes/No
29. Do you have any skin disorders (herpes, cold sores, rashes, acne, eczema)?	Yes/No
30. Have you had any chronic medical problems (chronic fatigue, thyroid condition, diabetes, etc.)?	Yes/No
31. Do you wear glasses or contacts for athletics?	Yes/No
32. Have you had any problems with your vision?	Yes/No
33. Do you regularly use braces, pads, mouth guards, assistive devices, neck rolls, goggles, etc.?	Yes/No
34. Have you ever received Chiropractic care?	Yes/No

Student Athlete Signature _____ Date _____

WHEATON COLLEGE, IL MEDICAL EXAMINATION FORM

This form will meet the medical exam requirement for general entrance and athletic participation. The medical examination must be within one year prior to date of entrance, unless student is an Intercollegiate Athlete, in which case the medical exam must be done 6 months or less prior to start of sport.

TO THE EXAMINING MEDICAL PROVIDER┼. Please review the student's medical history, complete the medical examination form, and comment on all abnormal answers. Please add any laboratory diagnostic exams that are age/medical history appropriate.

Name_____ **Student ID #**_____ **□ M □ F Date of Birth**_____

Wt.	Ht.	BMI Please utilize the CDC.gov BMI calculator	Pulse	B/P
LMP date:	Regular □Yes □No	How many periods in a year?	Medications:	Allergies:
Contact Lenses □Yes □No Glasses □Yes □No	Vision:	Corrected:_____ Uncorrected: _____	R 20/_____ L 20/_____	Food Allergies:

Clinical Evaluation

Check each item in appropriate column, at right. Enter "N.E." if not evaluated.	Normal	Abnormal	Check each item in appropriate column, at right. Enter "N.E." if not evaluated.	Left	Right	Normal	Abnormal
1. Appearance			16. Musculoskeletal Exam				
2. Skull, Scalp, Face, Neck, Thyroid			C-Spine				
3. Nose and Sinuses			Thoracic, Lumbar, Sacral Spine				
4. Mouth (tongue, gingivae, teeth)			Other				
5. Throat and Tonsils				**Left**	**Right**		
6. Ears (Int. and Ext. canals)			Shoulder				
7. Eyes (pupils, E.O.M., conjunctiva)			Elbow				
8. Lungs and Chest (include Breasts)			Wrist				
9. Heart (rhythm, sounds, and Murmurs. Examine in sitting, recumbent, and leftrecumbent positions before and after exercise.)			Hand/Fingers				
10. Abdomen/Pelvis and Viscera (include hernia)			Hip				
11. Endocrine System			Upper Leg				
12. G-U System (optional for females) males: testes			Knee				
13. Skin			Lower Leg				
14. Lymphatic Glands			Ankle				
15. Nervous System			Feet/Toes				
			Other:				

Required: Recommendations for physical activity for intercollegiate, intramurals, club sports, travel abroad, general education requirements, internships. (Please complete or student cannot compete/participate):

_____Cleared without restriction

_____Cleared, with recommendations for further evaluation or treatment for: _____

_____Not Cleared for___All Sports___ Certain Sports: _____

Reason for Non-Clearance: _____

Recommendations:_____

If this student is an intercollegiate athlete, they must acknowledge education of sickle cell screening through blood test, waiver, or consent to testing. For further information, visit NCAA.org. To request a waiver for this test, please contact the Wheaton College Athletic Department at 630-752-5738.

┼Intercollegiate Athletes must complete Medical Examination by a M.D. or D.O per NCAA rules and Wheaton College Athletic Department.

┼M.D., D.O., PA, or NP Signature_____Date_____Phone

Medical Providers name (please print or use stamp)_____ Fax _____

Address _____

Name:_____ **Student ID #**_____ **Date of Birth:** _____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Student: please fill out and submit form to SHS as this is part of your entrance medical requirements, even if you have not had any prior testing.

Prior Testing: Have you had a TB skin test (PPD)? ☐ No ☐ Yes If yes, result: ☐ Negative ☐ Positive Date:_____

Have you had a TB blood test (IGRA)? ☐ No ☐ Yes If yes, result: ☐ Negative ☐ Positive Date:_____

Please answer questions 1-16 and provide an explanation if the answer is "YES."	**Explanation**
1. Have you ever been told by a doctor or healthcare provider that you had active TB?	□ **Y** □ **N**
2. Have you ever taken medication for TB? Which medication(s)? What year?	□ **Y** □ **N**
3. Have you ever had a BCG vaccine for TB? (BCG does not exempt you from this requirement)	□ **Y** □ **N**
4. Have you ever been told by a health care provider that your immune system is not working right or that you cannot fight infection? (e.g. immune disorder or illness)	□ **Y** □ **N**
5. Have you cared for, or lived with, anyone diagnosed with active TB disease in the past year?	□ **Y** □ **N**
6. Have you worked or volunteered in a setting where TB may be more common, such as a homeless shelter, nursing home, group home, or prison, in the past year?	□ **Y** □ **N**
7. In what country were you born?_____	
8. If you were not born in the USA, since what year have you been in the USA? _____	
9. Have you lived in any other country for greater than one year? If yes, where?_____	
10. Have you traveled outside the USA in the past year? □ **Y** □ **N** If yes, please provide the following information. Country_____ Length of stay (in days/weeks) _____ Country_____ Length of stay (in days/weeks) _____ Country_____ Length of stay (in days/weeks) _____	
11. Have you received a live vaccine in the past 6 weeks? (e.g. measles, mumps, rubella, chickenpox, or shingles)	□ **Y** □ **N**
12. Persistent coughing (3 weeks or more)	□ **Y** □ **N**
13. Coughing up blood or bloody sputum	□ **Y** □ **N**
14. Night sweats (soak the sheets)	□ **Y** □ **N**
15. Unexplained weight loss?	□ **Y** □ **N**
16. Unexplained, excessive fatigue?	□ **Y** □ **N**
17. Fever of unknown origin?	□ **Y** □ **N**

SHS will review this form and reply to your my.wheaton email account if you need an individual plan for further testing or treatment. Treatment may include a PPD skin test(s) or an IGRA blood test. Depending on your individual plan, these services may be available through Student Health Services.

For non-SHS Medical Providers, please use TB SCREENING SUPPLEMENT FOR MEDICAL PROVIDERS (page 6) to provide additional documentation.

Name:_____ **Student ID #**_____ **Date of Birth:** _____

IMMUNIZATIONS REQUIRED BY WHEATON COLLEGE

Certain immunizations are required by the State of Illinois for all incoming college students. Other immunizations are recommended by Wheaton College. This form must be completed in English, including month, day, and year for each immunization. Alternatively, you may attach an official immunization report. Report must include healthcare provider signature or office stamp.

*TETANUS/DIPHTHERIA/PERTUSSIS

3 doses required. One dose must be Tdap, the most recent dose must be received within 10 years prior to term of current enrollment. At least six months required between 2nd and 3rd dose.

DIPHTHERIA, PERTUSSIS, TETANUS or DIPHTHERIA, TETANUS	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	#4 _____ MONTH DAY YEAR	LATEST BOOSTER _____ MONTH DAY YEAR	***Tdap** _____ MONTH DAY YEAR

*Consider Tdap/Adacel for Booster if appropriate

*MENINGITIS CONJUGATE (Menactra or Menveo)

***MCV4 (Menactra or Menveo) Must have 1 dose on, or after, age of 16 years old**	_____ MONTH DAY YEAR

*M.M.R. (Measles, Mumps, Rubella)

Two doses of M.M.R. at least 28 days apart after 12 months old. Born before 1957, no immunization required.

M.M.R. (MEASLES, MUMPS, RUBELLA)	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR

----------Fill out this portion ONLY IF M.M.R. requirement has not been met.----------

MEASLES (Rubeola): If given instead of M.M.R., two doses **required**. Dose #1 given **1/1/68** or later **and after first birthday**. (MMR is preferred for second dose – see MMR section.) Dose #2 given at least 30 days after initial dose **OR** Report of Immune Titer.*
MUMPS: If given instead of M.M.R., two doses **required** given **1/1/68** or later **and after first birthday OR** report of Immune Titer.*
RUBELLA (German Measles): If given instead of M.M.R., one dose **required** given **1/1/68** or later **and after first birthday OR** Report of Immune Titer. *

MEASLES	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	TITER RESULTS
MUMPS	#1 MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	TITER RESULTS
RUBELLA	#1 MONTH DAY YEAR		TITER RESULTS

***Attach copy of ALL lab reports in English.**

IMMUNIZATIONS RECOMMENDED BY WHEATON COLLEGE

POLIO Recommended *Please circle which vaccine given

OPV (oral) *Or* IPV (injected)	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	#4 _____ MONTH DAY YEAR	#5 _____ MONTH DAY YEAR

HEPATITIS B Recommended (Three doses of vaccine OR a positive surface antibody)

HEPATITIS B IMMUNIZATION	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	HEPATITIS B SURFACE ANTIBODY	_____ MONTH DAY YEAR	RESULT: _____ REACTIVE _____ NON-REACTIVE

VARICELLA (CHICKENPOX) Recommended (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart)

HISTORY OF DISEASE YES_____NO_____OR
DATE_____/_____/_____
MM DD YEAR

VARICELLA ANTIBODY	_____ MONTH DAY YEAR	RESULT: _____ REACTIVE _____ NON-REACTIVE
IMMUNIZATION	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR

OTHER IMMUNIZATIONS RECEIVED (i.e. Hepatitis A, Typhoid, HPV, Yellow Fever, Meningitis B, Menomune, etc.)

	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	#4 _____ MONTH DAY YEAR	#5 _____ MONTH DAY YEAR
	#1 _____ MONTH DAY YEAR	#2 _____ MONTH DAY YEAR	#3 _____ MONTH DAY YEAR	#4 _____ MONTH DAY YEAR	#5 _____ MONTH DAY YEAR

Required Medical Provider Signature_____ **Date**_____
Print Name_____ **Phone**_____ **Fax:**_____
E-mail_____ **Address:** _____

Immunization Exemption Policy By Illinois State law, a student may be exempt from immunizations for one of only two reasons: medical or religious. To request an immunization exemption form, please email Student.Health.Services@wheaton.edu. All completed forms will be reviewed by the Director of Student Health Services for approval. This is part of the entrance requirements.

TB SCREENING SUPPLEMENT FOR MEDICAL PROVIDERS

This page should be provided to your medical provider if a new PPD skin test has been administered or an IGRA blood test has been completed based on the information on the TB Screening Questionnaire (page 4). **Student please provide this supplement to your medical provider to complete if they administered/performed one of these tests. If you have prior testing or TB Treatment, please provide the official report(s).**

Patient Name_____/_____/_____
Last First Date of birth Student ID number

TST/PPD Date obtained_____/_____/_____ Date read_____/_____/_____ Month Day Year Month Day Year Results_____Interpretation _____	If positive, refer to CDC.gov rubric. Progress to IGRA testing
Interferon Gamma Release Assay (IGRA) Date obtained_____/_____/_____ (specify method): ϒ QFT ϒ T-Spot Month Day Year Result: negative_____positive_____indeterminate /borderline_____ *Report attached*	If IGRA positive, progress to chest x-ray
Chest X-ray: (Required if IGRA is positive) Date of chest x-ray_____/_____/_____ Result: ϒ normal ϒ abnormal *Report attached* Month Day Year	
Medication Section: Were they advised to take medication because of the positive results? No_____Yes_____ If yes, did they accept medication? No_____Yes _____ If yes, what medication(s) were prescribed? _____ Date Started:_____/_____/_____Date Ended:_____/_____/_____	

Additional Notes:

1. If BCG was received, an IGRA is preferred to a PPD.
2. If immune deficient, testing may be falsely negative and there is greater risk of progression from LTBI to active disease
3. If a live vaccine was recently received or patient is ill, consider delaying IGRA testing until 4-6 weeks after vaccination or illness to avoid a false positive result.
4. If PPD positive complete IGRA. If IGRA is positive, send chest x-ray results

TUBERCULOSIS (TB) RISK ASSESSMENT- Management of Positive TST or IGRA

All students with a positive IGRA with no signs of active disease on chest x-ray should receive recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ϒ Infected with HIV
- ϒ Recently infected with *M. tuberculosis* (within the past 2 years)
- ϒ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease.
- ϒ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplant.
- ϒ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck or lung
- ϒ Have had a gastrectomy or jejunoileal bypass
- ϒ Weigh less than 90% of their ideal body weight
- ϒ Cigarette smokers and persons who abuse drugs and/or alcohol

Health Care Provider

Name _____Signature_____
Address _____
_____
_____Fax_____Phone _____

WHEATON COLLEGE STUDENT HEALTH SERVICES MEDICAL FORMS

MyWheaton.edu email is the official communication of Wheaton College. Please be sure to check your Wheaton College email regularly for updates on your submitted health requirements and other college announcements.				
Form	**Form**	**Form**	**Form**	**Form**
Page 1-2 Medical History	Page 3 Medical Examination	Page 4 Tuberculosis Screening Questionnaire	Page 5 Required Immunizations and Recommended Immunizations	Page 6 Tuberculosis Screening Supplement for Medical Providers* ***If necessary**
Filled out by student* **Complete page two ONLY if student athlete** ***Parent is to fill out Minor Consent if student is a minor on or after first day of school**.	Filled out by M.D., D.O., NP, or PA ***If you are an Intercollegiate Athlete, the Medical Examination must be completed and signed by a MD or DO per NCAA rules and Wheaton College Athletic Department within six months of the start of sport**	Filled out by student	Filled out by Medical Doctor, Physician Assistant, or Nurse Practitioner with office stamp OR can submit official record of immunizations from office with office stamp	Filled out by Medical Doctor, Physician Assistant, or Nurse Practitioner with office stamp* *Required only if MD, PA, or NP administers TB Test.

2 easy way to submit your forms securely:	
Preferred Method: **Submit your forms through Northwestern MyChart. All communication will be done through MyChart.** Your MyChart access code will be provided through your my.wheaton.edu email address. Please be looking for this email with your MyChart letter with your unique access code from Student Health Services' email from May 15-June 5, 2020. **OR** Mail to: Wheaton College, Student Health Services, 501 College Ave, Wheaton, IL 60187, postmarked by July 15, 2020.	**Incomplete Student Health Services Requirements:** Due to COVID-19, we realize it may be challenging to schedule an appointment with your family physician. Therefore, we are setting a *preferred* deadline of **July 15, 2020 by 11:59pm CST**. **Phone: 630.752.5072**