



For Office use

Initials

Louisiana Tech University
Student Health Center
 P.O. Box 3023
 Ruston, LA 71272
 Phone: (318)257-4866
 Fax: (318)257-3927

MEDICAL HISTORY

Student Information (Please Print)

All information is confidential and is reviewed by Health Center Personnel only.

Name _____
 (Last) (First) (Middle)

Social Security # or Student ID: _____ Date of birth ____/____/____ Age _____ Sex _____

Address _____
 (Street) (City) (State) (Zip Code)

Telephone: (____) _____ Cell: (____) _____ Are you planning on living: __On Campus __Off Campus

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Family History

Has any member of your family ever had any of the following? (Please check)

- | | | | |
|------------------------------------------------|----------------------------------------------|------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Rheumatism(arthritis) | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Stomach, Intestinal Trouble | <input type="checkbox"/> Tuberculosis |

Personal History

List any surgeries: _____

List any medical conditions you are currently being treated for: _____

List any medications you take on a regular basis: _____

List any serious illnesses: _____

List any food or drug allergies: _____

Comments: _____

Insurance

Type	Company	Policy	Exp. Date
Accident and Hospitalization			
Automobile			

Name: _____ Social Security Number: _____

TUBERCULOSIS QUESTIONNAIRE
(MANDATORY – NO EXEMPTIONS)

The Student Health Center is evaluating all entering students for exposure to tuberculosis (TB). Please review and complete the information below **even if you have received a BCG (TB) vaccination in the past.** If you have any questions, please contact the Student Health Center at (318) 257-4866.

Have you ever had a positive PPD skin test in the past?	YES	NO
If yes, <u>STOP</u>. Please provide evidence of treatment and chest x-ray results.	_____	_____

PAST HISTORY

- | | YES | NO |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Were you born in, have you ever lived in, or recently traveled to (within the past 5 years) any country in the following areas of the world?
<i>Africa, Asia, Caribbean nations, Central America (including Mexico), Eastern Europe, India and other Indian Subcontinent Nations, Middle East, Portugal, South America, South Pacific (except Australia and New Zealand), or Spain</i> | _____ | _____ |
| 2. Do you have a history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use? | _____ | _____ |
| 3. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility? | _____ | _____ |
| 4. Do you have an AIDS/HIV or take immunosuppressive medication such as prednisone? | _____ | _____ |
| 5. Have you been in close contact with someone with TB? | _____ | _____ |

IMPORTANT: If you answered “YES” to any of the above 5 questions listed under PAST HISTORY, you are required to have a PPD skin test within the past year. You can obtain the PPD skin test from your physician or student health center. If you answered NO to all of the above, no further action is required.

NOTE TO HEALTH CARE PROVIDERS: Please record the size of the induration in millimeters. If there is no reaction, please record as “0 mm”. **Students who have had a BCG vaccine are still required to have a PPD skin test.** If the screening skin test is positive (10mm or greater for those who answer “YES” to questions 1, 2, or 3, and 5mm or greater for those who answer “YES” to questions 4 or 5), we require an appointment at the public health clinic or please provide a copy of treatment and chest x-ray result. **You will not be allowed to attend classes until you have been seen by Lincoln Parish Health Unit TB division or until you provide documentation of previous treatment and chest x-ray result.**

Date PPD Applied: _____ Date PPD Read: _____ Size of Induration: _____ mm Site of PPD: _____

Health Care Provider’s Name: _____ Health Care Provider’s Signature: _____

Referred to Public Health Unit: Yes _____ No _____ Appointment Date: _____

REMEMBER! You will not be eligible to register for classes until all immunization records are in compliance or the exemption is signed.

RETURN THIS FORM TO:

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