Name_____DOB___/___/___

MARLBORO COLLEGE
TOTAL HEALTH CENTER
Phone: 802-258-9335

Report of Health History

Please complete the first five pages of the form below before going to your Health Care Provider

Name _____ **Birth Date** _____
Last **First** **Middle** **Maiden**

Marital Status: _____ **Single** _____**Married** _____**Other** **Cell phone** _____

Family Health Status

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Primary Care Provider_____ **Phone**_____

Address_____

YOU MUST INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE AND PHARMACY CARD, IF APPLICABLE

☐ I don't have health insurance

Please return this form to:

Marlboro College Total Health Center
PO Box A
Marlboro, VT 05344

Or fax to: 802-251-7604

In addition you must submit the **Emergency Contact form** online by visiting **www.marlboro.edu** and clicking on **Incoming Students** and selecting **Forms**.

https://www.marlboro.edu/communities/incoming_students/

Name_____DOB___/___/___

Rights and Responsibilities of Students Utilizing the Marlboro College Total Health Center

As an individual utilizing the Marlboro College Total Health Center You Have the Right to:

1. Be treated with respect, dignity, and consideration.
2. To expect that all personnel who care for you to be knowledgeable and current in the skills of their profession.
3. Privacy.
4. Confidentiality (Except in emergency situations, information regarding visits to the Health Center is not released to any other persons without prior consent).
5. Information regarding your diagnosis and treatment options.
6. Participate in decisions involving your health care whenever possible.
7. Be respected for your opinions and beliefs regarding your health care.
8. To refuse treatment, and/or seek another opinion.

You Have A Responsibility To:

1. Provide accurate and complete information to the Health Center.
2. Ask questions regarding your care and make use of information and resources available.
3. Express your grievances and/or suggestions rather than remaining silent.

Marlboro College Total Health Center Statement of Privacy

Personal Health/Mental Health information of students receiving care in the Marlboro College Total Health Center is confidential and held separate from any other information regarding a student. Personal health information is accessed only by staff of the Total Health Center, which includes consulting Physicians as appropriate. In the event the Total Health Center staff feels it is important to share personal health information outside the Total Health Center, or information is requested by an outside source, it will be done so only with the student's written authorization. *

In the interest of providing optimal collaborative care to a student, personal health information may be shared/discussed between providers in the Total Health Center on an as needed basis. In such situations, only the information necessary to provide optimal care to a student will be discussed/shared between providers.

***In emergency situations where an individual's health/safety is at risk, limited information may be released without written authorization.**

I have read, understand and agree to the above statements.

Student_____**Date**_____

Name_____DOB___/___/___

Health History

(To be completed by student.)

Important: We urge you to be completely thorough and honest in providing Marlboro College with the requested information. ***This section may be removed from the section to be completed by PARENTS AND HEALTH CARE PROVIDERS to ensure your privacy and encourage honest and complete answers.*** It is crucial for our Health Center staff to be aware of any prior health/psychological difficulties in order for us to act in your best interest should a crisis arise.

Some of the information you provide may be shared with the College psychological counseling staff. Information provided will not be shared outside the Health or Counseling departments without prior contact with you. Contact with your health care provider or psychological counselor will be made only after contact with you.

IF YOU CHECK YES TO ANY QUESTION, PLEASE DESCRIBE PROBLEM IN DETAIL AT THE END OF THIS QUESTIONNAIRE.

1. Give a brief statement of your health in general. _____

_____

2. Do you have any present medical problem?.....Yes No

3. Does your health prevent you from participating in any physical activities?.....Yes No

4. Are you taking any medications? (Including oral contraceptives)……...Yes No

If yes, list all medications, dose and reason for taking:

5. Have you had serious childhood illnesses or broken bones?.....Yes No

6. Have you had any surgeries or been hospitalized for any reason?.....Yes No

(Describe and give approximate date)

7. Are you allergic to any of the following:

(Describe severity of reaction and medication taken for control).

Medications (identify) .... Yes No

Foods (identify) .... Yes No

Insect bites (identify insect) .... Yes No

Other allergies (please identify) .... Yes No

If yes to any allergies, do you need to carry an epi-pen? ..... Yes No

8. Do you smoke? If so, how much? ..... Yes No

9. Have you had, or do you have, a problem with alcohol or other drugs?..... …….Yes No

If so, please explain

10. Have you ever been diagnosed with a Learning Disability? ..... Yes No

11. Have you ever been diagnosed with a ADHD?..... Yes No

12. Do you have problems with your vision or hearing? ..... Yes No

Do you wear glasses? ..... Yes No

Name_____DOB___/___/___

Do you wear contact lenses ..... Yes No
Do you wear hearing aids ..... Yes No

13. Have you ever had episodes of irregular heartbeat, shortness of breath or chest pain? ..... Yes No

If yes, please describe symptoms and explanations provided to you.

14. Do you have asthma? ..... ……Yes No
15. Have you had, or do you have, ulcers, heartburn, or other gastrointestinal problems? ..... Yes No
16. Do you require a special diet? ..... ……Yes No
17. Do you have or have you had any eating disorders; i.e., anorexia, bulimia, compulsive eating?. Yes No
18. Have you had hepatitis or jaundice?.... ……...Yes No
19. Have you had frequent bladder/kidney infections? ..... Yes No
20. Do you or have you had seizures?..... Yes No
If yes, when was your last seizure?

21. Do you suffer from severe or frequent headaches? ..... Yes No
22. Have you had problems with dizziness or fainting?..... Yes No
23. Do you have problems with your neck, back, arms, ankles or knees that limits your activity? ... Yes No
24. Do you have bleeding problems? ..... Yes No
25. Do you have diabetes, hypoglycemia, thyroid problems or other endocrine problems? ..... Yes No
26. Do you have any chronic skin problems (rash, acne, etc.)? ..... Yes No
27. Have you ever been in therapy or under treatment of a therapist, psychologist or psychiatrist?.. Yes No
If yes: Currently under treatment? ..... Yes No

Under treatment within the past two years? ..... Yes No
Were you hospitalized or in a residential treatment facility? ..... Yes No

Reasons for treatment:

Family issues Divorce Career Depression Substance Abuse

Attempted Suicide Academic Other _____

For women:

Is your menstrual cycle regular? ..... Yes No
Are your periods painful? ..... Yes No
Do you have premenstrual problems? ..... Yes No
Have you ever had a gynecological exam? ..... Yes No
Are you using any contraceptive method? ..... Yes No
Have you ever had an abnormal pap smear? ..... Yes No

** If you are utilizing a contraceptive method that will require administration or refill while here at Marlboro you must provide a copy of an exam and laboratory results performed within the past 12 months or have an examination here in our health center.

If you checked YES to any question in this questionaire, please describe in detail below.

Name_____DOB___/___/___

MARLBORO COLLEGE PHYSICAL EXAM FORM – PART I

Medical History

(to be completed by student and reviewed with examining provider)

Have you had or do you have any of the following? Please mark your responses below.

	current	past	no
28. ADHD	☐	☐	☐
29. Allergies to:			
Medication	☐	☐	☐
Food	☐	☐	☐
Bees	☐	☐	☐
Environmental	☐	☐	☐
30. Anemia	☐	☐	☐
31. Asthma	☐	☐	☐
32. Back Problems	☐	☐	☐
33. Blood Disorder	☐	☐	☐
34. Bowel Problems	☐	☐	☐
35. Breast Abnormality	☐	☐	☐
36. Cancer	☐	☐	☐
37. Impaired immunity	☐	☐	☐
38. Chicken Pox	☐	☐	☐
39. Chronic Constipation	☐	☐	☐
40. Chronic Diarrhea	☐	☐	☐
41. Concussion	☐	☐	☐
42. Diabetes	☐	☐	☐
43. Ear trouble/Hearing loss	☐	☐	☐
44. Eye problems	☐	☐	☐
45. Eating Disorder	☐	☐	☐
46. Dizziness/fainting/blackouts	☐	☐	☐
47. Dental problems	☐	☐	☐
48. Loss of consciousness	☐	☐	☐
49. Headaches, frequent	☐	☐	☐
50. Headaches, migrane	☐	☐	☐
51. Heart disease	☐	☐	☐
52. Heart Murmur	☐	☐	☐
53. Hepatitis/Jaundice	☐	☐	☐
54. Hernia	☐	☐	☐
55. High Blood Pressure	☐	☐	☐
56. High Cholesterol	☐	☐	☐

	current	past	no
57. Joint Disease/injury	☐	☐	☐
58. Kidney Disease	☐	☐	☐
59. Malaria	☐	☐	☐
60. Measles, German (Rubella)	☐	☐	☐
61. Measles, Red (Rubeola)	☐	☐	☐
62. Menstrual Problems	☐	☐	☐
63. Depression	☐	☐	☐
64. Anxiety disorder	☐	☐	☐
65. Other Mental Health Issues:	☐	☐	☐
66. Suicide Attempt	☐	☐	☐
67. Mononucleosis	☐	☐	☐
68. Mumps	☐	☐	☐
69. Palpitations/Heart	☐	☐	☐
70. Pneumonia	☐	☐	☐
71. Rheumatic Fever	☐	☐	☐
72. Reflux/Heart Burn	☐	☐	☐
73. Scoliosis	☐	☐	☐
74. Seizure Disorder	☐	☐	☐
75. Sexually Transmitted Disease	☐	☐	☐
76. Shortness of breath	☐	☐	☐
77. Sinus trouble	☐	☐	☐
78. Skin trouble	☐	☐	☐
79. Sleep Disturbance	☐	☐	☐
80. Stomach trouble/ulcers	☐	☐	☐
81. Substance Abuse	☐	☐	☐
82. Thyroid disorder	☐	☐	☐
83. Tuberculosis	☐	☐	☐
84. Urinary Tract Infection	☐	☐	☐
85. Weakness/Paralysis	☐	☐	☐
86. Other	☐	☐	☐

Health Care Providers, please elaborate on any positive answers:

_____

_____

_____

_____

_____

Name_____DOB___/___/___

MARLBORO COLLEGE PHYSICAL EXAM FORM – PART II

Please do not use alternatives to this form**.**

Must be completed and signed by a Physician, Nurse Practitioner or Physician's Assistant. Provider may not be a relative of the patient.

Height _____ **Weight** _____ **B/P** _____ **Pulse**_____

Eyes: Vision without glasses: Right _____ Left _____
With glasses: Right _____ Left _____
Contacts? Y__ N__ Date of last eye exam _____

Ears: Drums: Right _____ Left _____
Hearing: Right _____ Left _____ Discharge? R ___ L ___

Nose and Throat _____Tonsils_____

Teeth: _____ Gums _____ Date of Last Dentistry _____

Neck: (Thyroid size, enlarged nodes, etc.) _____

_____

Chest: (Size, symmetry, etc.) _____

Lungs: _____

Breasts: _____

Heart: Size_____ Rhythm_____ Murmur? _____

Abdomen: (Scars, masses, hernias etc.) _____

_____

Extremities: _____

Neurologic: _____

Skin: (Acne, etc.) _____

Urinalysis: Sp. Grav. _____ Alb._____ Sugar_____ Hgb/Hct. _____

Tuberculosis screen as outlined by CDC Positive____Negative____Comments_____

PPD required if screen is positive*:* Date given: __/__/__Date read: __/__/__ Results_____

Women: Date of most recent PAP Smear (if applicable) _____

Medications currently prescribed:

PROVIDER NAME: _____

ADDRESS: _____

_____

PROVIDER SIGNATURE _____ DATE: _____

Name_____DOB___/___/___

MARLBORO COLLEGE

TOTAL HEALTH CENTER

Immunization Record

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

REQUIRED IMMUNIZATIONS

A. M.M.R. (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after 1956.)

1. Dose 1 given at age 12 months or later. . . . . #1 ___/___/___

2. Dose 2 given at least 28 days after first dose. . . . . #2 ___/___/___

B. VARICELLA

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of Disease Yes _____ No _____ or Birth in U.S. before 1980 Yes _____ No_____

2. Varicella antibody ___/___/_____ Result: Reactive _____ Non-reactive _____

3. Immunization

   a. Dose #1 . . . . . #1___/___/___

   b. Dose #2 given at least 12 weeks after first dose ages 1-12 years #2___/___/___

   and at least 4 weeks after first dose if age 13 years or older.

C. TETANUS-DIPHTHERIA-PERTUSSIS

(Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years

1. Primary series of four doses with DTaP, DTP, DT, or Td:
#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. (Administer with MCV4 simultaneously if possible). . . . . ___/___/___

3. Booster: Td within the last ten years. . . . . ___/___/___

D. HEPATITIS B

(Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (hepatitis B)
a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___

Adult formulation___ Child formulation___ Adult formulation___ Child formulation___ Adult formulation___ Child formulation___

2. Immunization (Combined hepatitis A and B vaccine)
a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___

3. Hepatitis B surface antibody Date ___/___/___

Result: Reactive_____ Non-reactive_____

E. MENINGOCOCCAL TETRAVALENT

(A,C,Y,W-135 / One dose — for first year student living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world.

- Menactra - Tetravalent conjugate (preferred; data for revaccination pending; administer simultaneously with Tdap if possible): ___/___/___
- Menomune - Tetravalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues): Date ___/___/___

Name_____DOB___/___/___

MARLBORO COLLEGE
TOTAL HEALTH CENTER

Immunization Record

RECOMMENDED IMMUNIZATIONS

F. POLIO

(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)
1. OPV alone (oral Sabin three doses): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

2. IPV/OPV sequential: IPV #1 ___/___/___ IPV #2___/___/___ OPV #3 ___/___/___ OPV #4 ___/___/___

3. IPV alone (injected Salk four doses): #1___/___/___ #2 ___/___/___ #3___/___/____ #4___/___/____

G. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)

(Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)
Immunization (HPV)
a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___

H. INFLUENZA

___/___/___

I. HEPATITIS A

1. Immunization (hepatitis A)
a. Dose #1 ___/___/___ b. Dose #2 ___/___/___

2. Immunization (Combined hepatitis A and B vaccine)
a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

(One dose for members of high-risk groups.)
Date ___/___/___

K. OTHER

Vaccine _____ Date _____

Vaccine _____ Date _____

Vaccine _____ Date _____

HEALTH CARE PROVIDER

Name _____

Address_____Phone (___)_____

Signature _____

Name_____DOB___/___/___

MARLBORO COLLEGE
TOTAL HEALTH CENTER

AGREEMENT

My signature below indicates that:
The information on this form is correct and complete to the best of my knowledge.

Signature of student _____

Date _____

Consent Form For Permission To Treat Minors

(Must be completed if student is under the age of 18)

I hereby give my permission for the providers at the Marlboro College Total Health Center to provide acute and routine health care to the student named below. Such care may include the ordering of prescription medications (eg: antibiotics or immunizations for travel) or, in the case of an emergency, securing appropriate medical treatment that may include transport to the local Emergency Room, hospitalization, anesthesia, or surgery.

Student _____ D.O.B. _____

Parent/Guardian _____

Address _____

Telephone (Home) (_____)_____

(Work) (_____)_____

(Cell) (_____)_____

Parent/Guardian Signature _____