



# SAMUEL MERRITT UNIVERSITY

<p>Samuel Merritt University – Student Health Services</p> <p>Peralta Medical Office Building 3100 Telegraph Avenue, Suite 3105 Oakland, CA 94609</p> <p>Telephone [510] 869-6629, Fax [510] 869 6212</p>	<p><b>Office Hours:</b></p> <p><u>Mon. – Fri.</u> 9:00 a.m. – 5:00 p.m.</p> <p><b>Nurse Practitioner Hours:</b></p> <p><u>Monday</u> 9:00 a.m. – 12:30 p.m. <u>Wednesday</u> 10:00 a.m. – 5:00 p.m. <u>Friday</u> 10:00 a.m. – 5:00 p.m.</p>
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## **Congratulations on your admission to Samuel Merritt University, and welcome to Student Health Services!**

### **SERVICES**

We invite you to utilize our clinic for your primary health care needs during your academic tenure. We provide health care maintenance and screening, as well as care for on-going and acute health needs. Services include urgent care, diagnostic care, management of chronic conditions, family planning, and referral to specialists.

Office visits for illness or consultation are free of charge to enrolled students. Drop-ins are welcome, but appointments are preferred and will help us assess each student's needs prior to visits. Our fees are listed below, with full payment required at the time of service, payable in check or exact cash only.

PPD Skin Test	No charge	Hepatitis B vaccine	\$125 per dose
Tetanus booster	\$50	MMR vaccine	\$60 per dose
Physical Exam*	\$75	Varicella vaccine	\$85 per dose

\* *Physical Exam (by appointment) fee includes physical exam, vision screening, and urinalysis.*

For any x-rays, laboratory tests (e.g., complete blood count, titres, other bloodwork, Pap smear), or other diagnostic tests needed, we can refer you to Summit Medical Center. You will be charged separately by Summit for services done through the hospital; arrangements may be made with them to bill your private health insurance, if applicable.

### **REQUIRED FORMS**

**All students are required to complete the attached *Student Health Record* and return it directly to Student Health Services prior to University entrance.** Incomplete forms or forms received after the deadline will hold up your registration process. Submit the *Student Health Record* and documentation to us either by mail, fax, or drop by our office. Inform us directly of any future changes to your name, local mailing address, and/or local phone number.

You are welcome to have your physical exam and immunizations done at Student Health Services, for a fee. Physical exams can only be scheduled after all other requirements are completed. Students with private health insurance should consult their own healthcare provider. Bring the Physical Exam form (page 3) to your provider; you may also need his/her assistance in completing the Immunization History (page 2). If your exam is scheduled at a later date, submit the rest of the forms first (page 1 and pages 4 - 8), making note of your appointment date, so we can begin preparing your medical chart.

*Mandatory Student Health Insurance Forms* should be returned directly to Student Services at Bechtel Hall. For questions regarding the school insurance option, contact Student Services at (510) 869-6627.

**Save this cover letter for future reference, and keep copies of the completed health forms for your own files.** We look forward to meeting and working with you!



STUDENT ID (Office Use Only):

## STUDENT HEALTH RECORD

LAST NAME	FIRST	MIDDLE	GENDER	SOCIAL SECURITY #	DATE OF BIRTH (MM/DD/YYYY)
<b>LOCAL</b>				<b>CONTACT NUMBERS</b>	
Address:				Local Home Phone: (   )	
City/State/Zip:				Mobile Phone: (   )	
<b>PERMANENT HOME ADDRESS (If different)</b>				Permanent Home Phone: (   )	
Address:				E-mail Address:	
City/State/Zip:					
<b>EMERGENCY CONTACT</b>				<b>NAME OF HEALTH INSURANCE</b>	
Name:				Prior to University Enrollment:	
Relationship:				During University Enrollment:	
Address:					
City/State/Zip:					
<b>EMERGENCY CONTACT NUMBERS</b>				<b>TERM ENTERING (circle one)</b>	
Home Phone: (   )				Fall      Spring      Summer	
Work Phone: (   )					
<b>ACADEMIC PROGRAM ENTERING (circle one)</b>					
ABSN	BSN	ELMSN / ELFNP (Oakland)	ELMSN / ELFNP (Sacramento)	FNP	CRNA
				MPA	MOT
				DPT      DPM	

### Consent for Treatment and Limited Release of Records

**CONFIDENTIALITY:** Unless you give permission, no confidential information (other than as indicated below) is provided to any other department of the University or to anyone or other organization outside the University. In addition, the information you provide on these forms is not seen by the Admission staff and does not impact consideration of your application for admission.

**TREATMENT:** I hereby authorize Student Health Services/Summit Medical Center to provide such medical services as deemed necessary during the period of time that I am a student at Samuel Merritt University.

**LIMITS OF RELEASE OF RECORDS:** I give permission for Samuel Merritt University Student Health Services to make available information regarding dates of my completion of exams and immunization requirements and PPD testing results to my clinical instructors and to the clinical institutions where I will train.

The information provided above and on the attached forms is complete and true to the best of my knowledge.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

*(for students under 18 years old)*

Date: \_\_\_\_\_

### These forms must be RETURNED TO STUDENT HEALTH prior to University entrance.

Incomplete forms and forms received after the deadline will hold up your registration process. You may mail, fax, or drop off completed forms to Student Health Services. Remember to keep copies for your own files. Call us for any questions or appointments.

Student Name: \_\_\_\_\_

## Immunization History



**You must either:** **1)** Submit written documentation, by attaching copies of your childhood/school immunization records, immunization card, hospital or physician's records, lab reports, etc.;

**or, 2)** Have your healthcare provider (physician, physician assistant, or nurse practitioner) verify dates and results from your records, fill out, and sign this form.

Any bloodwork done for titres/antibodies must show positive immunity; otherwise, vaccination series will need to be completed. All dates must be in MM/DD/YYYY format.

Health Requirement	Dates (MM/DD/YYYY)	Result / Immunity	Notes
<b>HEPATITIS B</b> Vaccines (3 doses)	1. 2. 3.		
<b>or</b> Hepatitis B sAb Titre	1.	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<i>If negative, need vaccines.</i>
<b>TETANUS</b> Booster	1.		<i>Within last 10 years.</i>
<b>MMR</b> —MEASLES, MUMPS, RUBELLA Vaccines (1 or 2 doses, see note)	1. 2.		<i>1 dose if born before 01/01/1957; 2 doses if born on or after 01/01/1957</i>
<b>or</b> Rubeola IgG Titre	1.	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<i>If any are negative, need vaccines.</i>
Rubella IgG Titre	2.	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	
Mumps IgG Titre	3.	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	
<b>VARICELLA</b> Vaccines (2 doses)	1. 2.		<i>History of Varicella does <u>not</u> fulfill this requirement. If you had the chickenpox, have your titre checked.</i>
<b>or</b> Varicella Zoster IgG Titre	1.	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	<i>If negative, need vaccines.</i>
<b>PPD</b> —TB SKIN TEST Negative PPD	1.	<input type="checkbox"/> Neg.	<i>PPD within 6 months before University entrance.</i>
<b>or</b> Positive PPD History	1.	<input type="checkbox"/> Pos.	<u>Induration (mm):</u> <i>X-ray within 12 mos. before University entrance.</i> <u>Findings:</u>
Chest X-Ray	2.	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.	
TB Screening Survey	3.		

I have verified all dates and results, and certify them to be correct to the best of my knowledge.

Health Provider Signature: \_\_\_\_\_  
 Name and Title: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

Date Signed: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_

Student Name: \_\_\_\_\_

**Physical Exam**



**All exams and tests must be done within 12 months before University entrance.**

Please have this form completed and signed by your healthcare provider (physician, physician assistant, or nurse practitioner). All dates must be in MM/DD/YYYY format.

VISION SCREENING (Snellen)	Right Eye	Left Eye	Both Eyes
Without Correction			
With Correction			
Correction Type			
<i>If done at separate facility or on separate date, sign here:</i>	Provider Signature: _____ Name and Title: _____ Telephone: _____	Exam Date: _____ Address: _____ City/State/Zip: _____	

General Appearance: \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ B/P \_\_\_\_\_

Check if normal or describe abnormal findings:

- |  |   |
|--|---|
| <input type="checkbox"/> Skin: _____         | <input type="checkbox"/> Chest: _____                       |
| <input type="checkbox"/> Head: _____         | <input type="checkbox"/> Back: _____                        |
| <input type="checkbox"/> Eyes: _____         | <input type="checkbox"/> Breasts: _____                     |
| <input type="checkbox"/> Ears: _____         | <input type="checkbox"/> Heart: _____                       |
| <input type="checkbox"/> Nose: _____         | <input type="checkbox"/> Abdomen/Hernia: _____              |
| <input type="checkbox"/> Mouth/Throat: _____ | <input type="checkbox"/> Genitalia: _____                   |
| <input type="checkbox"/> Neck/Thyroid: _____ | <input type="checkbox"/> Extremities/Musculoskeletal: _____ |
| <input type="checkbox"/> Nodes: _____        | <input type="checkbox"/> Neuro: _____                       |

LAB TESTS	Date (MM/DD/YYYY)	Results (or attach copy of lab reports)
Complete Blood Count (CBC)	_____	_____
Urinalysis (UA)	_____	_____

FINDINGS	PLAN
_____	_____
_____	_____
_____	_____

Immunizations given: \_\_\_\_\_  
 Pending laboratory results, and when expected: \_\_\_\_\_  
 Pending x-ray results, and when expected: \_\_\_\_\_  
 Restrictions for University or clinical work setting, if any: \_\_\_\_\_

Health Provider Signature: _____	Exam Date: _____
Name and Title: _____	Address: _____
Telephone: _____	City/State/Zip: _____

Student Name: \_\_\_\_\_

## Tuberculosis Screening Survey (POSITIVE PPD History Only)



**NOTE: Do not submit this page if you have a negative PPD.**

Complete this page only if you have had a **positive PPD skin test** result in the past. You will need to fill out a new survey at Student Health Services every 12 months while a student.

1. Date of last **positive** PPD (MM/DD/YYYY): \_\_\_\_\_ Test Result: \_\_\_\_\_ mm induration
  
2. Where were you born? \_\_\_\_\_  
If you were born outside of the United States, how long have you been here? \_\_\_\_\_
  
3. Have you had vaccinations with Bacillus of Calmette & Guerin (BCG)?  Yes  No  Don't know  
If "Yes": When? \_\_\_\_\_ Where? \_\_\_\_\_
  
4. Have you ever traveled, worked, and/or lived outside the United States?  Yes  No  
If "Yes":                      Dates    Places  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Are you aware of any exposure to people with possible active TB (i.e., high-risk populations, such as refugees, immigrants, homeless individuals, persons with chronic cough, or household members with TB infection)?  
 Yes  No If "Yes," describe nature of possible exposure: \_\_\_\_\_  
\_\_\_\_\_  

Dates	Places	Length of Contact
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. During the past 12 months, have you noticed any of the following?

	Yes	No		Yes	No
Productive cough (3 weeks)			Swollen glands, usually in neck		
Persistent weight loss without dieting			Recurrent kidney or bladder infections		
Persistent low grade fever			Coughing up blood		
Night sweats			Shortness of breath		
Loss of appetite			Chest pain		

Please provide details of any "Yes" answers above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Student Name: \_\_\_\_\_

**CONFIDENTIAL MEDICAL HISTORY:** On the following pages, if you need to list additional items or explanations, utilize any extra space within the section or continue on the back side of the appropriate page (making note of this within that section).

## Personal Health History



Check all that apply, if you have or have had any of the following.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Emotional abuse          | <input type="checkbox"/> Lupus erythematosus                |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Migraine headache                  |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Neurological disorders             |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Frequent urine infection | <input type="checkbox"/> Physical abuse                     |
| <input type="checkbox"/> Auto-immune disease    | <input type="checkbox"/> Hearing problems         | <input type="checkbox"/> Sexual relations against your will |
| <input type="checkbox"/> Back injury or surgery | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Sickle cell disease                |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Skin problems                      |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Hernia                   | <input type="checkbox"/> Stomach or bowel ulcers            |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Drug/alcohol abuse     | <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Vision problems                    |
| <input type="checkbox"/> Eating disorder        | <input type="checkbox"/> Learning disability      | <input type="checkbox"/> Weight loss or gain                |

## Surgeries and Hospitalizations



List dates, types of surgery (if applicable), and reasons for hospitalization.

Date

Surgery or Hospitalization

_____	_____
_____	_____
_____	_____

Describe any other significant health conditions you may have, including physical limitations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provide details of any conditions that you have indicated above.

Condition & Current Status

How Controlled

Dates of Onset & When Resolved

_____	_____	_____
_____	_____	_____
_____	_____	_____

Student Name: \_\_\_\_\_

## Personal Habits



Briefly describe your current dietary and exercise habits.

Diet: \_\_\_\_\_

Exercise: \_\_\_\_\_

Check all that apply:	How much?	How much?	
<input type="checkbox"/> Smoke cigarettes	_____	<input type="checkbox"/> Drink coffee	_____
<input type="checkbox"/> Smoke cigars	_____	<input type="checkbox"/> Drink tea	_____
<input type="checkbox"/> Chew tobacco	_____	<input type="checkbox"/> Drink soda (caffeinated)	_____
		<input type="checkbox"/> Drink alcohol	_____

## Allergies



List allergies to any medications and other substances, and describe the type of reaction to each.

Allergy	Reaction
_____	_____
_____	_____
_____	_____

## Medications



List all medications you are currently taking. Include birth control pills, vitamins, medicinal herbs, and non-prescription medications.

Medication	Strength	Dose & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Student Name: \_\_\_\_\_

**Family Medical History**



Please check all that apply.

Illness	Mother	Father	MGM*	MGF*	PGM*	PGF*	Siblings	Children
Alcoholism								
Allergies								
Asthma								
Cancer, breast								
Cancer, gastrointestinal								
Cancer, other **								
Chronic lung disease								
Diabetes								
Heart disease								
High blood pressure								
Osteoporosis								
Stroke								
Thyroid disease								

\* *MGM (maternal grandmother), MGF (maternal grandfather)*  
*PGM (paternal grandmother), PGF (paternal grandfather)*

\*\* For other cancers, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History (Optional)**



List all members of your household. Include spouse or significant other, children, other family members, and any other people who live with you.

Name	Relationship	Age	Current Health Status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Student Name: \_\_\_\_\_

## Gynecological and Obstetrical History (For FEMALES Only)



**NOTE: Males do not submit this page.**

### MENSTRUAL HISTORY

Do you have regular menses?  Yes  No

Cycle length: \_\_\_\_\_ Duration: \_\_\_\_\_ Date of last known menstrual period: \_\_\_\_\_

### REPRODUCTIVE HISTORY

Indicate number of (if any): Pregnancies: \_\_\_\_\_ Miscarriages and/or Abortions: \_\_\_\_\_

Are you currently using any method of birth control?  Yes  No

If "Yes," what method? \_\_\_\_\_

### PAP SMEAR HISTORY

If you have ever had a pelvic exam, what was the date of your last Pap smear? \_\_\_\_\_

Have you ever had an abnormal Pap smear?  Yes  No

If "Yes":	Date	Treatment	Follow-up status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### BREAST EXAM HISTORY

Date of your last breast exam by a healthcare provider: \_\_\_\_\_

Have you been taught to do self breast exams?  Yes  No

If "Yes," how often do you perform self breast exams? \_\_\_\_\_

### HISTORY OF PELVIC DISEASE/DISCOMFORT

Have you had any significant pelvic disease?  Yes  No

If "Yes":	Date	Treatment	Follow-up status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____