Health Screening Form

PART I

Date ______________________________

Name (print) ____

SSN___________________________

Cell Phone ____

Date of birth ________________________

Address(home)____

Name of parent/guardian/other who may be contacted____

It is the philosophy of the staff of Trinity Health Services to provide you with the best care possible. To accomplish this, it is important for us to review significant health issues that might impact your health. You may leave any question blank if you choose. **This history form is a confidential document that will be kept in your medical record in Health Services. No information may be released without your written consent, unless required by law.**

Section I

Allergies (list all)

Allergy	Type of reaction
_________	____________________________
_________	____________________________
_________	____________________________
_________	____________________________

Current medications (including over-the-counter or herbal)

Medication	Dosage if known
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

Hospitalizations / surgery (list all)

Year	Reason
_________	____________________________
_________	____________________________
_________	____________________________

Serious illnesses or injuries (not including hospitalizations)

Year	Reason
________________________	________________________
________________________	________________________
________________________	________________________

Health habits

1. Have you ever used tobacco regularly? ❑ Yes ❑ No
2. Do you currently smoke cigarettes or use smokeless tobacco? ❑ Yes ❑ No
   If yes, how often? _________________ Do you want to quit? ❑ Yes ❑ No
3. Do you exercise regularly? ❑ Yes ❑ No
   If yes, what type? _________________________________
4. Do you have concerns about your appearance or weight? ❑ Yes ❑ No

Family history Have any close relatives (parents, siblings) ever had any of the following (check all that apply)?

❑ Allergies
❑ Blood or clotting disorders
❑ High cholesterol
❑ Diabetes
❑ Hereditary disease
❑ High blood pressure
❑ Depression / psychiatric illness
❑ Tuberculosis
❑ Heart disease
❑ Cancer
❑ Stroke
❑ Other serious illness

Explain any checked items:____
____
____
____

Section II

Personal history Have you had or do you now have any of the following? If yes, note date of occurrence if known.

	Yes	No	Date
Head / neurological			
Frequent headaches/migraines	❑	❑	__________
Dizziness or fainting	❑	❑	__________
Loss of consciousness	❑	❑	__________
Head injuries	❑	❑	__________
Eyes			
Vision or eye problems	❑	❑	__________
Glasses or contact lenses	❑	❑	__________

	Yes	No	Date
Gastrointestinal			
Abdominal pain (severe / recurrent)	❑	❑	__________
Ulcer	❑	❑	__________
Bowel movement problems	❑	❑	__________
Blood in stool	❑	❑	__________
Hepatitis	❑	❑	__________
Hernia	❑	❑	__________
Miscellaneous			
Cancer	❑	❑	__________
Unusual fatigue (over 1 month)	❑	❑	__________
Recent gain or loss of weight (over 10 pounds)	❑	❑	__________
Eating disorder	❑	❑	__________

Health Screening Form

Name____

Section II (cont.)

Personal history Have you had or do you now have any of the following? If yes, note date of occurrence if known.

	Yes	No	Date
Genitourinary			
Urinary or kidney problems	❑	❑	__________
Ears / Nose / Throat			
Allergies or hay fever	❑	❑	__________
Ear or hearing problems	❑	❑	__________
Frequent sinusitis	❑	❑	__________
Dental problems or TMJ	❑	❑	__________
Skin			
Severe acne or skin disorder	❑	❑	__________
New or changing moles	❑	❑	__________
Blood disorder			
Anemia	❑	❑	__________
Bleeding disorder	❑	❑	__________
Enlargement of glands or lymph nodes	❑	❑	__________
Heart / circulation / chest			
Severe chest pain or pressure	❑	❑	__________
Heart disease or murmur	❑	❑	__________
Rapid or irregular pulse	❑	❑	__________
Blood clots or vein problems	❑	❑	__________

	Yes	No	Date
Musculoskeletal			
Swollen or painful joints or extremities	❑	❑	__________
Chronic or severe back problems	❑	❑	__________
Chronic diseases			
Diabetes mellitus	❑	❑	__________
Asthma	❑	❑	__________
High blood pressure	❑	❑	__________
Arthritis	❑	❑	__________
Sickle cell disease	❑	❑	__________
Seizures or epilepsy	❑	❑	__________
Thyroid disease	❑	❑	__________
Elevated cholesterol	❑	❑	__________
Respiratory			
Chronic cough (over 1 month)	❑	❑	__________
Pneumonia	❑	❑	__________
Tuberculosis or positive PPD	❑	❑	__________
Asthma	❑	❑	__________

Other: ____

____

Explain all "Yes" answers above ____

____

____

Section IV Mental health issues

1. Do you have any questions or concerns regarding any of the following?:
   - family alcoholism or drug abuse ❑ Yes ❑ No
   - pregnancy (you or your partner) ❑ Yes ❑ No
   - rape, sexual abuse, or unwanted sexual activity ❑ Yes ❑ No
   - physical abuse ❑ Yes ❑ No
   - dating or domestic violence ❑ Yes ❑ No
   - death of a loved one within the past 12 months ❑ Yes ❑ No
2. Do you feel sad or lonely? ❑ Yes ❑ No ❑ Sometimes
3. Do you feel depressed? ❑ Yes ❑ No ❑ Sometimes
4. Do you have difficulty with sleep patterns? ❑ Yes ❑ No ❑ Sometimes
5. Do you have difficulty controlling your temper? ❑ Yes ❑ No ❑ Sometimes
6. Do you drink alcohol? ❑ Yes ❑ No
7. On any *single* occasion during the past three months, have you had had more than four alcoholic drinks at one sitting? ❑ Yes ❑ No
8. Have you used narcotics, stimulants, cocaine, LSD, or other street drugs more than once? ❑ Yes ❑ No
9. Do you use marijuana? ❑ Yes ❑ No
10. Do you frequently use tranquilizers or sleeping pills? ❑ Yes ❑ No
11. Do you have any mental health disorder? ❑ Yes ❑ No If yes, what kind? __________________________
    Present or past medications prescribed for this condition ____

Have you ever felt you should CUT down on your drinking? ❑ Yes ❑ No
Have others ANNOYED you by criticizing your drinking? ❑ Yes ❑ No
Have you felt GUILTY about your drinking? ❑ Yes ❑ No
Have you had to use first thing in the am to steady your nerves? ❑ Yes ❑ No

Health Screening Form

Name____

Section III Sexuality
Answers to the following confidential questions help your clinician provide appropriate care for you. ***Leave questions blank if you are uncomfortable answering them.*** *Please feel free to discuss any concerns with your clinician.*

1. Have you ever been sexually active (i.e. any genital contact with another person)? ❑ Yes ❑ No
   If your answer is *no,* skip to question #7.
2. Are you currently sexually active? ❑ Yes ❑ No
3. Are you married? ❑ Yes ❑ No
4. Have your sexual partners been: ❑ Men ❑ Women ❑ Both
5. Have you ever had any of the following STDs (sexually transmitted diseases):

			If yes, dates/comments
chlamydia	❑ Yes	❑ No	____________________
pelvic inflammatory disease	❑ Yes	❑ No	____________________
genital warts / HPV	❑ Yes	❑ No	____________________
herpes	❑ Yes	❑ No	____________________
other	❑ Yes	❑ No	____________________

6. If sexually active, do you use safe sex practices (condom, dental dam, etc.)? ❑ Yes ❑ No
7. Are you presently using a method of birth control? ❑ Yes ❑ No
   If yes, what type? ____
   Do you have questions about birth control methods? ❑ Yes ❑ No
8. Would you like to know more about abstinence or secondary abstinence? ❑ Yes ❑ No
9. Has your sexuality or sexual preference ever been a problem for you? ❑ Yes ❑ No
10. Men: Do you do routine self-testicular exams? ❑ Yes ❑ No
    Have you ever taken steroids or other performance-enhancing drugs? ❑ Yes ❑ No
11. Women: Do you do routine self-breast exams? ❑ Yes ❑ No
    Do you have regular menstrual periods? ❑ Yes ❑ No
    Do you have menstrual pain severe enough to affect your daily functions? ❑ Yes ❑ No
    Have you ever had a pelvic examination before? ❑ Yes ❑ No
    If yes, date of your last pap smear or pelvic exam? _____________

STATEMENT OF AUTHORIZATION TO TREAT

I authorize Health Services to administer medical services (including immunizations and allergy injections), to perform emergency procedures, and/or to defer treatment to a local physician or hospital if deemed necessary. I have reviewed the health information provided here and attest that the above information is accurate and complete. **I understand that this confidential information will not be shared without my written consent except in an emergency situation**. (To be reviewed at least annually)

Signature of Student	Provider	Date
Signature of Student	Provider	Date
Signature of Student	Provider	Date
Signature of Student	Provider	Date
Signature of Student	Provider	Date
Signature of Student	Provider	Date

Trinity College
Part II
Student Health Evaluation

DATE_______NAME____

DOB_______________AGE____

Height_______Weight_________BP_______________Pulse_______________
Allergies______Medicaltion(list_)________________Latex__Y__N_________
Food(list)_______________________Environmental(list)__________________
Vision : Uncorrected   Corrected: O.D_____________O.S_______________
Hearing: Satisfactory   Deficient
Right ear_____________________
Left Ear______________________

System	Normal	Abnormal (explain)
HEENT		
Heart		
Lungs		
Abdomen		
GI		
GU		
Neurologic		
Musculoskeletal		
Head		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Skin		
GYN		
Dental/Oral		
Other		

Are there any restrictions on physical activity?_____Y______N

Clearance for athletic participation:
Cleared______
Cleared after completing evaluation/rehab for________
Not cleared for:____Collision____Contact_____Strenuous____Moderatly Strenuous
Due to____

List any medications or treatments that the student should continue at school.

____

____

____

____

____

____

How long have you known the student?_____________

Date of examination_______________________________

Signature of healthcare provider_______________________

Print Name/address/phone number of healthcare provider

____

____

____

____

Return to :

Trinity College
Health and Wellness Center
125 Michigan Avenue
Washington, DC 20017

Immunization Record

<u>This for must be completed by your health care provider in order to register for classes</u>

The District of Columbia requires that every student who is under the age of 26 at the time of registration must be immunized against seven (7) contagious diseases.

Required Immunizations

- Three (3) doses of polio vaccine
- Three (3) doses of DPT in childhood and a booster of Tetanus/Diphtheria(TD) within the last 10 years.
- Two (2) doses of measles/mumps/rubella(MMR) after 12 months of age, at least 1 month apart.

Recommended Immunizations

- TB Skin Test
- Varicella Dose 1 and 2 or a History of Chicken Pox
- Hepatitis B (3 doses)
- Meningitis Vaccine

Please have the health care provider complete and sign the reverse side of this form and return to :
Trinity Health and Wellness Center
125 Michigan Ave NE
Washington, DC 20017

Name________________________________DOB____
Home Address____
SSN____

Required Immunizations **DATE**

1. Tetanus/Diptheria _____
2. TD Booster _____
3. MMR Dose 1 _____
4. MMR Dose 2 _____
Or
Positive antibody titer _____
5. Polio Dose 1 _____
6. Polio Dose 2 _____
7. Polio Dose 3 _____

Recommended Immunizations/screening

1. Varicella Dose 1 _____
2. Varicella Dose 2 _____
Or
Positive Varicella Titer _____
3. Hepatitis Dose 1 _____
4. Hepatitis Dose 2 _____
5. Hepatitis Dose 3 _____
7. Meningococcal Vaccine _____
(strongly recommended)
8. PPD _____
Result Neg____
Result Pos______CXR result_____ _____

Provider Signature____Date_____________________

Office
Address____
____
____
____

A copy of up-to-date records may be attached by provider in lieu of completing form.

Trinity Health and Wellness Center
HIPAA Notice of Privacy Practices

This notice describes how medical/health information about you may be used or disclosed and how you can get access to this information. Please read it carefully, sign on the last page, and return to the Health and Wellness Center.

Your Health Information

Each time you visit the Health and Wellness Center, a record of your visit is made. It contains you medical history, symptoms, results of testing and examinations, lists of medications and plan of care. Your health information contains personal information and there are state and federal laws to protect the privacy of your health information.

Use and Disclosures of Information

Treatment
All staff involved in your care will document in your record and have access to the information it contains. We may forward information to other providers involved in your care.

Training
Periodically, health program students participate in services at the Health and Wellness Center. These students have signed confidentiality agreements prior to having any access to a medical record.

Payment
A bill will be sent to your insurance carrier for some services received at the Health and Wellness center. The information accompanying the bill may include information that identifies your diagnosis, treatments and supplies used. We may also contact your insurance company to confirm coverage.

Healthcare Operations
The Health and Wellness Center is subject to quality review by insurance and other entities and may review medical records in the course of such reviews.

Other Disclosures

Business Associates
Some of our services, such as laboratory work are provided through other business entities. To protect your health information, we require business associates to protect the information as well.

Communication with others
Health professionals may disclose information to persons or family members if you have consented in writing. We may communicate with insurers regarding payment for your care.

Research

Occasionally, health related information may be used for research purposes. All research projects are subject to special approval.

As required by Law
Health Information may by disclosed to the following types of entities:

- Food and Drug administration
- Public Health or authorities charged with disease prevention
- Correctional Institutions
- Workers Compensation Agents
- Organ and tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, medical examiners
- National Security and Intelligence Agencies
- Law enforcement as required by law or in accordance with a valid subpoena
- To avoid serious threat to the health and safely of a person or the public.

Patient Rights

You have the right to;

- Request a restriction on certain uses and disclosures of your information; we are not required to agree with your request. Even if we do agree to your restriction, some emergency situations may require release of information.
- Obtain a paper copy of this notice of privacy practices.
- Inspect and obtain a copy of your health record.
- Request an amendment to your health record.
- Obtain an accounting of disclosures of your health record.
- Request communication of your health information in a certain way or certain location.
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken.
- To register complaints regarding the privacy of your medical information to_______

To exercise any of your rights, please submit your request in writing to the Health Center.

Our duties are:

- To maintain the privacy of your health information
- To provide you with a notice of our privacy practices
- To abide by the terms of this notice.
- To notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you make for communicating information.

Trinity Health and Wellness Center

Acknowledgement of receipt of Notice of Privacy Practices

I have been provided with the Notice of Privacy Practices that provides a description of medical information uses and disclosures.

I have been given the opportunity to read and review the notice prior to signing this form.

I understand that Trinity College has the right to change its current practices and these changes will be posted.

I understand I have the right to restrict how some medical information may be disclosed. I understand that Trinity University is not required to agree to my restriction.

I understand that I may revoke this acknowledgement in writing, except to the extent action has already been taken.

______________________________________ ______________

Signature of Patient or Legal Representative Date