

Name: _____

FAMILY MEDICAL HISTORY

Please indicate all biological family members who have experienced any of the following conditions. If deceased, age at time of death. (i.e., Asthma, paternal grandfather, 96).

Biological family member	If deceased, age
Asthma _____	
Cancer, (type) _____	
High Blood Pressure _____	
Diabetes _____	
Heart Disease _____	
High Cholesterol _____	
Thyroid Condition _____	
Tuberculosis _____	
Alcoholism _____	
Other serious chronic disease (specify) _____	

PERSONAL MEDICAL HISTORY

Any allergies (medication) _____ (food) _____ (others) _____

Tobacco Use Yes No _____ Pack a day _____ Years _____ I quit _____ ago
other tobacco products (specify) _____

Alcohol Use Yes No How often _____ Quantity/Amount _____

List any surgery, hospitalizations (including psychiatric), illnesses, or significant injuries and approximate dates: _____

List any medications you are taking (including birth control pills/non-prescription pills):

Please describe any ongoing medical problem: _____

For women only: most recent pap and pelvic exam if any (date and result): _____

Student's Signature

Date

Name: _____

PHYSICAL EXAMINATION

(Within one year prior to admission)

All Information Is Required. Form Must Be Completed By A Health Care Provider

Height: _____ Weight: _____ BP: _____ Pulse: _____

Skin: _____

Head: _____

Eyes: _____ Snellen R/20 _____ L/20 _____

Corrected R/20 _____ L/20 _____

Contact lens/glasses _____

Ears: _____

Nose: _____

Mouth and Throat: _____

Neck: _____

Thorax: _____

Lungs: _____

Breast: _____

Spine/Back: _____

Heart: _____

Abdomen: _____

Genito-urinary (if indicated) _____

Extremities: _____

Lymph Nodes: _____

Reflexes: _____

Laboratory exam: Hematocrit: _____ % urine sugar _____ urine protein _____

Does this student have a medical condition for which ongoing health care is required? _____

May this student participate in athletic activities? Any restrictions or contraindications? _____

Recommendations for health care at Caltech? _____

Signature of Health Care Provider

Date of Exam

IMMUNIZATION RECORDS

Name: _____ Birthdate: _____

Last First

Address: _____

To be **completed** and **signed** by your health care provider. **All information must be in English.**

A. MMR (Measles, Mumps, Rubella) REQUIRED (Two doses required)

1. Dose 1 given at age 12 months or later #1 _____
mo/day/year
2. Dose 2 given at least 28 days after first dose #2 _____
mo/day/year
- OR**
3. Report of positive immunity (attach copy of report) Immune _____ Not Immune _____

B. Tuberculosis Screening (Mantoux) REQUIRED within **SIX MONTHS PRIOR TO ADMISSION**

(A history of BCG vaccination should not preclude testing)

TB skin test _____ mm induration _____
mo/day/year (required) signature of health care provider

CXR (required if tuberculin skin test has a positive reaction >10mm) result: _____ mm

Date of chest x-ray _____ Normal _____ Abnormal _____ if abnormal, attach copy
mo/day/year

C. Tetanus-Diphtheria (Td) REQUIRED

Primary series of four with DTaP or DTP _____
year completed

Booster: Tdap (preferred) _____ **OR** Td within the last ten years _____
mo/day/year mo/day/year

D. Hepatitis B REQUIRED (First 2 doses received prior to arrival at Caltech, third dose can be completed at Caltech)

Dose #1 _____ Dose #2 _____ Dose #3 _____
mo/day/year mo/day/year mo/day/year

OR Hepatitis B surface antibody (attach copy of report) Reactive _____ Non-reactive _____

E. Meningococcal vaccine REQUIRED for freshmen undergraduate students, persons with terminal deficiencies or asplenia. Non-freshmen students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.

(In the last 5 years) _____ Menactra (preferred) Menomune
mo/day/year

F. Hepatitis A (strongly recommended) 2 doses at least 6-12 months apart

(First dose prior to arrival at Caltech. Second dose can be completed at Caltech)

Dose #1 _____ Dose #2 _____
mo/day/year mo/day/year

G. Polio (recommended) Primary series should be complete _____ Booster, if any _____
year completed mo/day/year

H. Varicella (recommended) Either a positive varicella antibody, or two doses of vaccine given at least one month apart, if immunized after age 13 years.

Dose #1 _____ Dose #2, given at least one month after first dose if age 13 years or older _____
mo/day/year mo/day/year

OR Varicella antibody (attach copy of report) reactive _____ non-reactive _____

Health Care Provider _____ Date signed _____

Address _____ Tel. No. _____

