PLEASE INDICATE STUDENT STATUS

RSMD ☐ SAS ☐

Talbot ☐ SOE ☐

ICS ☐ GBS ☐

Previous Biola Student? Y N

Last Semester Attended?

BIOLA UNIVERSITY
STUDENT HEALTH CENTER

13800 BIOLA AVENUE

LA MIRADA, CA 90639-0001

PH: 562- 903-4841 ⅄ FAX: 562-906-4512

PLEASE LIST DRUG/FOOD/BEE ALLERGIES

GRADUATE STUDENT HEALTH HISTORY

Biola ID ________________ M ☐ F ☐

Last Name ________________ First Name ________________ Middle Initial ________

Address ________________ Home Phone # ________________

City, State, Zip ________________

Birthplace ________________ Age ________ Date of Birth ________________

Citizenship ________________ Ethnicity (opt.) ________________

Emergency contact & Relationship: ________________ Phone # ________________

PERSONAL HISTORY

History of injuries &/or operations: (Give nature & year) ________________

History of previous illness: (give year &/or status)

Appendicitis ________ Epilepsy ________ Pneumonia ________

Asthma ________ Kidney Disease ________ Rheumatic Fever ________

Cardiac Condition ________ Malaria ________ Seasonal Allergies ________

Diabetes ________ Mononucleosis ________ Tuberculosis ________

Have you had any other severe illness not mentioned above? If so, please explain. ________________

Number of Pregnancies ________ Number of Live Births ________

Can you eat a normal, balanced diet? ________ If not, explain. ________________

In what sports do you regularly participate? ________________

Emotional problems? (be specific) ________________

Have you ever used any psychoactive or addicting drugs, with or without a prescription? Please explain.

GENERAL APPEARANCE

Height ________ Weight ________

EYES: Color ________ Last eye exam ________ Vision Corrected ________ Uncorrected ________ Contacts? Y N Glasses? Y N

TEETH: Last visit to dentist ________ Need dental work? ________

FAMILY HISTORY

Name	Alive	Chronic Illnesses?	Deceased	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Spouse				
Children				

Have any of your family or blood relatives ever had any of the following illnesses? Please give relationship.

Asthma	High Blood Pressure
Cancer (type)	Kidney Disease
Diabetes	Mental Disturbance
Heart Disease	Tuberculosis
Any chronic illness not mentioned	

**** (See other side for Immunization and Tb validation requirements)**

IMMUNIZATION RECORD - ******PLEASE UPDATE IF NEEDED ******

Tetanus-Diphtheria (booster within the last 10 years): ____________________

M.M.R. (Measles, Mumps, Rubella): Dose 1 ____________________ Dose 2 _______________ (two dates needed)

Measles (Rubeola): disease date __________ Mumps: disease date __________ Rubella: disease date __________

Polio: Completed primary series? Yes No date of last booster ____________________

Hepatitis B (opt.): Dose 1 __________________ Dose 2 __________________ Dose 3 __________________

Hepatitis A (opt.): Dose 1 __________________ Dose 2 __________________

Menactra A/C/Y/W-135 (Meningococcal vaccine) (opt.)______________ Recommended by ACHA (American College Health Assoc.)

***Current (within 1 year) Mantoux TB testing is REQUIRED for all undergrad and graduate students. Must be completed in the United States.**

MANTOUX TB TEST VALIDATION

Student Name: ____

Biola I.D.#___________________________________

Solution and Dosage_____________________________________Site_____________________________________

Given By: ________________________________Date Applied ______________Time Applied _______________
Clinician's Name

Induration: __________________________mm Impression: ____

Read By: _________________________________Date Read _________________Time Read _________________
Clinician's Name

Chest x-ray and further evaluation required if TB test is positive.

**If you have had a previously documented positive TB test, you must provide chest x-ray results within the past year and have further evaluation.*