UNIVERSITY OF GUAM
STUDENT HEALTH SERVICE
UOG STATION MANGILAO, GUAM 96923
TEL: 735-2226 • FAX: 734-4651

REPORT OF MEDICAL HISTORY

TO THE STUDENT: The University of Guam requires that each student submit a medical history. Students' health records are for the use of the Student Health Service and will not be released or disclosed to anyone without the student's knowledge or permission. The University of Guam does not discriminate on the basis of disability in the recruitment and admission of students or the operators of any of its programs and activities, as specified by federal laws and regulations. The designated coordinator for University compliance with Section 504 of the Rehabilitation Act of 1973 is the Registrar. This information is treated confidentially and does not become part of your academic records. Please type or print answers in English. ***(Please use BLACK or BLUE ink)***

STUDENTS NAME: _____ SEX: _____ MARITAL STATUS: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

HOME ADDRESS: _____ ZIP CODE: _____ PHONE: _____

ADDRESS: _____ ZIP CODE: _____ PHONE: _____

FAMILY HISTORY				
Family Member	Age	State of Health	Age at Death	Cause of Death
FATHER				
MOTHER				
BROTHERS				
SISTERS				

IN CASE OF EMERGENCY NOTIFY:	
NAME	
Last First Relationship	
ADDRESS	
STREET	CITY
STATE	ZIP CODE
TELEPHONE ( )	
Area Code	

PERSONAL HISTORY

Please indicate YES or NO in all questions. Make appropriate comments in the space provided below or on a separate sheet of paper.

Have you had...	Yes	No	Have you EVER had...	Yes	No	Do you FREQUENTLY have...	Yes	No
SCARLET FEVER			PAIN IN THE CHEST			INSOMNIA (CAN'T SLEEP)		
RHEUMATIC FEVER			SHORTNESS OF BREATH			ANXIETY, WORRY		
MEASLES			ASTHMA			DEPRESSION		
GERMAN MEASLES			HAY FEVER			NERVOUSNESS		
MUMPS			ALLERGY			STOMACH TROUBLE		
CHICKEN POX			TUBERCULOSIS			DIARRHEA		
MALARIA			TUMOR OR CANCER			DIZZINESS, FAINTNESS		
VENEREAL DISEASE						PALPITATION		
RECENT GAIN/WEIGHT LOSS						HEADACHES		
ANY SURGERY						COLDS, SORE THROAT		
Have you had any illness or injury or been hospitalized other than already noted? (Give details)			Have you ever received treatment for a nervous condition or mental condition or mental/emotional problem? (Give details)			Has your physical activity been restricted?		

NOTE; Information regarding disability, voluntarily given or inadvertently received, will not adversely affect any admissions decision. If you should require special services because of your disability, you may notify the University Health Nurse or Vice President, Enrollment Management and Student Affairs. This voluntary self-identification allows the University of Guam to prepare appropriate support services to facilitate your learning. This information will be kept in strict confidence and has no effect on your admission to the University of Guam.

(OPTIONAL) Please check the appropriate box:

☐ Blind ☐ Deaf ☐ Paraplegic ☐ Quadraplegic ☐ Developmental Disability ☐ Speech Impediment ☐ Other

Thank you for taking time out in helping us help you. Please contact the University Nurse upon arrival on campus.

SEE REVERSE SIDE

_____ STUDENT'S SIGNATURE

_____ DATE

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The University of Guam requires all newly entering students to be immunized against MEASLES and RUBELLA (GERMAN MEASLES). This medical requirement will be strictly monitored and enforced due to the increasing occurrence of measles in adults throughout the Pacific and United States. It is recommended that these immunizations be administered before coming on campus. ***(Please use BLACK or BLUE ink)***

STUDENT'S NAME: _____
LAST FIRST MIDDLE

SOCIAL SECURITY NO: _____

DATE OF BIRTH: _____

PLEASE CHECK

NEW STUDENT: _____

RE-ENTRY: _____

GRADUATE SCHOOL: _____

LAST ATTENDANCE: SP:____ SU:____ FA:____

NEW ATTENDANCE: SP:____ SU:____ FA:____

REQUIRED IMMUNIZATIONS:

		Date of Last Immunization # 1	# 2	
Measles	(§)			
Mumps	(§)			(§ BORN IN OR AFTER 1957)
Rubella	(§)			

This requirement is to be waived if: 1) the individual was born before 1957 (when we can assume that the individual probably had measles as a child or 2) A physician has documented the diagnosis of measles in the past or 3) Serologic evidence of immunity can be presented.

PPD Date Given _____ Date Read _____ Results(mm) _____

Students must show valid documentation of TB skin test result conducted within six (6)months prior to entry into the University of Guam.

If PPD +: Attach Chest X-Ray Report and proceed to Department of Public Health & Social Services in Mangilao, TB Department to obtain health clearance.

RECOMMENDED:

Polio

_____

Diptheria

_____

Tetanus

_____

- Dates of immunizations must be indicated and signed by provider or immunization record submitted with Medical History Form.
- All corrections made must be initialed by provider (no-white-outs accepted).

COMMENTS:

_____
Signature MD/Nurse Date

_____
Name (PRINT/STAMP)

_____
Address