Ohio Northern University
Medical History

All students must submit this medical history form to Ohio Northern University (ONU) Health Center to complete the enrollment process. Be sure to sign page three of this form, if you are under age 18 years of age, your parents or legal guardian must also sign this form. Your medical history is confidential and will only be reviewed by ONU Health Center staff. Mail this form to: Ohio Northern University Student Health Center, 525 S. Main Street, Ada, Ohio 45810. **THIS FORM IS DUE by August 1st for Fall semester and January 1st for Spring semester.**

1. Name _____
Last First Middle

2. Address _____
Number & Street City State Zip

3. Telephone (_____) _____ 4. E-mail Address _____

5. Social Security Number _____ 6. Place of Birth _____

7. Date of Birth _____ 8. Age _____ 9. Sex: Male Female No Disclosure
Month Day Year

10. Race _____ 11. Any service disability Yes or No _____
Please indicate type

12. **Entering ONU as a: c Freshman c Sophomore c Junior c Senior c Graduate _____Semester _____Year**
**Students - Please complete this section

13. Major and/or Curriculum _____

14. College last attended, if applicable _____

15. Parents' Name _____ Phone (_____) _____

16. Parents' Address _____
City State Zip

17. In the event of an EMERGENCY, provide the name of one person other than your parents or guardian to be notified:

Name _____ Phone (_____) _____

Address _____ Relationship _____
City State Zip

FAMILY HISTORY

Among your blood relatives, (include parents, brothers, and sisters) is there any history of cancer, heart disease, high blood pressure, TB, stroke, obesity, migraines, diabetes, mental health, seizures, blood diseases, or other:

	Age	Write in disease or illness of family member	Occupation	If Deceased, Cause and age of Death
Father				
Mother				
Brothers				
Sisters				

CURRENT MEDICATIONS

List all medications with dosage and how often you are taking them (prescription, over the counter, vitamins or herbs):

Medication	Dosage	How often	Reason for medication?

ALLERGIES

List all known allergies (medication, food, latex, insect bites, pets, or environmental) and explain the reaction to each:

Allergy	Reaction

PERSONAL HEALTH HISTORY

If you have ever had any of the following, please state yes or no and at what age.

Infectious Diseases	Y	N	Age	**Heart and Lungs**	Y	N	Age	**Musculoskeletal**	Y	N	Age
Chicken Pox				Palpitations				Broken bones			
Measles				Chest pain				Back problems			
Mumps				Heart disease				Bone or joint deformity			
Whooping Cough				Heart murmur				Arthritis			
Mononucleosis				High blood pressure				Rupture or hernia			
Hepatitis or liver disease				Shortness of breath				Knee problems			
Scarlet or Rheumatic Fever				Pneumonia				Any paralysis or handicap			
Tuberculosis (TB)				Asthma							
Meningitis								**Mental Health**			
								Alternating moods			
Skin and Body				**Genitourinary**				Trouble concentrating			
Acne				Bladder or kidney disease				Suicidal thoughts			
Skin disease or rash				Kidney stone/blood in urine				Drug overdose			
Obesity				Sexually Transmitted Infections				Depression			
Anorexia or Bulimia				Urinary tract infections				Anxiety			
Neurological				**Gastrointestinal**				**Eyes, Ears, Nose and Throat**			
Headache or Migraines				Abdominal pain				Blurred vision			
Difficulty sleeping				Indigestion				Glasses or contacts			
Dizziness				Ulcers				Nose bleeds			
Fainting spells				Diarrhea				Sinus problems			
Seizures				Hemorrhoids				Hay fever			
Head injury				Rectal bleeding				Ear problems			
Metabolic				**Hematologic**				**Other:**			
Diabetes				Anemia							
Thyroid				Blood disease							
Low blood sugar				Sickle cell trait							
				Sickle cell anemia							

If yes to anything above, please explain; _____

_____

_____

Hospitalizations/Surgeries/Additional information: (at what age)?

_____

_____

_____

_____

Ohio Northern University Health Center
Immunization History

Date of Birth_____/_____/_____

Name _____
Last Name First Name MI

Address _____
Street City State Zip

All ONU students must disclose/provide the following vaccination dates. See your medical provider or local health department to obtain your records. Attached copies of your records are acceptable.

M.M.R. (Measles, Mumps, Rubella) (Two doses required)	Dose 1 ___/___/___ M D Y	Dose 2 ___/___/___ M D Y			
Tetanus-Diphtheria/Tdap (Provide last two doses or at least last dose)	Td Booster / Tdap ___/___/___ M D Y	Td Booster / Tdap ___/___/___ M D Y			
Polio (primary series in childhood meets requirement; three series are acceptable)	Dose 1 ___/___/___ M D Y	Dose 2 ___/___/___ M D Y	Dose 3 ___/___/___ M D Y	Dose 4 ___/___/___ M D Y	
Varicella (History of chicken pox, two doses of vaccine, or a positive antibody titer)	History of Disease ___/___/___ M D Y	Dose 1 ___/___/___ M D Y	Dose 2 ___/___/___ M D Y	Positive Antibody Titer ___/___/___ M D Y	
***Hepatitis B** (Highly recommended for all college students. Pharmacy, Nursing, Athletic Training, Clinical Lab Science majors are required to receive this vaccine series for clinical sites.) **http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/web%20team/features/Hep%20B%20FAQs%202014.ashx**	Dose 1 ___/___/___ M D Y	Dose 2 ___/___/___ M D Y	Dose 3 ___/___/___ M D Y	Positive Antibody Titer ___/___/___ M D Y	**Mark Refused if refused** **Refused____**
***Meningococcal MCV4 Meningitis** (Highly recommended for all college students. Pharmacy major are required to receive one dose for clinical rotations.) **http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/dis/immunizations/college%20immun/meningococcaldiseaseandcollegestudents%20121814.ashx**	Dose1 ___/___/___ M D Y	Dose 2 ___/___/___ M D Y	**Mark Refused if refused** **Refused _____**		
Influenza Vaccine (Recommended for all students during the flu season)	Dose ___/___/___ M D Y				
Covid-19 (SARS-CoV-2) Highly recommended for all students (Required for all Pharmacy and Nursing students in their clinical sites) Vaccine Manufacturer:	Dose 1 ___/___/___ M D Y	Dose 2 ___/___/___ M D Y	Other ___/___/___ M D Y	Other ___/___/___ M D Y	

*** Meningococcal MCV4 and Hepatitis B Vaccination Status Verification

I, the undersigned student (if 18 years of age or older) or parent (if student is under 18), have read and understand the information (see websites in above box) provided to me about Meningococcal Meningitis and Hepatitis B. I understand the benefits and risks of being vaccinated against these two diseases. The information above regarding my/my student's vaccination status is accurate and is being provided in compliance with the Ohio Revised Code, Section 3701.133, (B). Review above websites for more information.

Students Printed Name _____
(Please print legibly)

Signature of Student _____ Date _____

Signature of Parent _____ Date _____
(If the applicant is less than 18 years of age)