

**PLEASE INDICATE  
STUDENT STATUS**

RSMD  SOPS   
 Talbot  SOE   
 ICS  Other   
 Previous Biola Student? Y  
 N

**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 \_\_\_\_\_ Mononeucleosis \_\_\_\_\_ 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.*