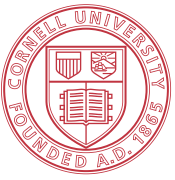

Cornell University

Please return this form to:
Cornell Health
110 Ho Plaza
Ithaca, NY 14853-3101

For information or assistance:
immunization@cornell.edu
607.255.4364

Faculty, Staff, Dependent of Enrolled Student

Health History Form

Welcome to Cornell Health. Known as a primary care facility for the health needs of students, Cornell Health offers a range of services to Cornell employees and eligible dependents of enrolled students. Cornell Health is accredited by the Accreditation Association for Ambulatory Health Care.

The information you provide here, as well as all health care at Cornell Health, is confidential**.** Cornell Health will not release any information about you without your written permission, except as authorized or required by law, or in our judgment as necessary to protect you or others from a serious threat to health or safety.

Cornell Health uses an electronic health records system, which provides a web portal (myCornellHealth) to facilitate secure communication with patients and clients. Visit *health.cornell.edu* for information regarding the services, staff, and resources available at Cornell Health.

PART ONE: IDENTIFICATION AND PRIVACY

IDENTIFICATION

Status ☐ Faculty member ☐ Staff member ☐ Dependent of enrolled student (specify) ____________________

Name ______________________ Date of Birth *(mm-dd-yyyy)* ______________ Gender______________
(last, first, middle)

Cornell ID# ______________________ Cornell Net ID ______________________

Address ______________________
Street or P.O. Box

____
City *State/Province* *Zip or Postal Code*

Phone Numbers Home ______________ Cell ______________ Work ______________

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name ______________________ Relationship ______________________

Phone Numbers Home ______________ Cell ______________ Work ______________

PRIVACY INFORMATION

Requires signature of the patient, and the parent/guardian *if an individual is under the age of 18.*

Cornell Health has a long-standing commitment to the rights and privacy of its patients and clients. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers to inform patients/clients of their Notice of Privacy Practices. Please review the Notice of Privacy Practices at health.cornell.edu. It describes our policy and the ways in which we use and protect your personal health information.

I acknowledge that I have been given the opportunity to read Cornell Health's Notice of Privacy Practices via the website.

☛ Signature(s) *Patient* ______________ *Parent/guardian*______________ Date (mm-dd-yyyy)____________

I consent to have Cornell Health use and disclose my protected health information for payment, treatment, and health care operations purposes. My protected health information means health, billing, and demographic information about me, collected from me, and created or received by Cornell Health. In the event Cornell Health participates with my health insurance, I authorize the payment of benefits to Cornell Health.

☛ Signature(s) *Patient* ______________ *Parent/guardian*______________ Date (mm-dd-yyyy)____________

FOR PATIENTS UNDER AGE 18: PERMISSION TO TREAT & SHARE NECESSARY HEALTH INFORMATION

I give my permission for my daughter/son/ward to receive health care from Cornell Health, Five Star Urgent Care, Cayuga Medical Center (including Convenient Care) and, if necessary, ambulance services in the event of an injury or illness. I understand that I will be responsible for all charges for health services provided by Cornell Health and by off-campus providers.

☛ Signature of parent/guardian ______________________ Date (mm-dd-yyyy) ______________

I understand that information about the immunizations my daughter/son/ward receives at Cornell Health will be shared with the New York State Immunization Information System (NYSIIS) as required by NY State Law. I have been made aware that information about this law is available at *health.ny.gov/prevention/immunization/information_system/parents/.*

☛ Signature of parent/guardian ______________________ Date (mm-dd-yyyy) ______________

PART TWO: HEALTH HISTORY

PERSONAL HEALTH CARE PROVIDER

Name ____ Work Phone ____________________
(last, first, middle) *(degree/title)*

Address ____
Street or P.O. Box

____
City *State/Province* *Zip or Postal Code* *Country*

PERSONAL HEALTH HISTORY

Check all you have had in the past or have at this time.

Alcohol, tobacco, and other drugs
- ☐ Alcohol use (#drinks/week_____)
- ☐ Tobacco use (#packs/week____)
- ☐ Other drugs *(specify)

☐ Asthma
☐ Autoimmune disorder
☐ Blood disorders, anemia
☐ Cancer

Cardiovascular disease
- ☐ Heart problem
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Pacemaker

☐ Eating disorder

Endocrine disorder
- ☐ Diabetes
- ☐ Thyroid
- ☐ Other *(specify)

☐ Eye disease
- ☐ Vision deficit

☐ Gastrointestinal condition *(specify)
☐ Head injury/concussion
☐ Hearing impairment
☐ Hepatitis B (acute or chronic)
☐ Hepatitis C
☐ HIV
☐ Hospitalization *(specify)
☐ Kidney disease

☐ Menstrual disorders
☐ Mental health disorder *(specify)
☐ Migraine headaches
☐ Mobility limitations *(specify)

Musculoskeletal problems
- ☐ Fractures *(specify)
- ☐ Other *(specify)

☐ Neurologic concerns
☐ Seizure disorder
☐ Surgical operations or procedure(s) *(specify)

* Please provide a brief explanation regarding history above. List metal implants, prostheses, and special needs you have. ____

____

____

____

ALLERGIES

Drug allergies

☐ No known drug allergies
☐ Acetaminophen
☐ Amoxicillin
☐ Aspirin
☐ Lidocaine/Xylocaine
☐ Penicillin
☐ Sulfa drugs
☐ Other drug allergy (specify below)

Other allergies

☐ No known "other" allergies
☐ Animals
☐ Foods
☐ Insect/bee sting
☐ Latex
☐ Xray contrast
☐ Other allergy (specify below)

Please provide a brief explanation of all allergies you indicated above. ____

____

MEDICATIONS (frequent or regular)

☐ Acne medication
☐ ADHD medication
☐ Allergy medication
☐ Allergy shots
☐ Antidepressant medication
☐ Asthma medication
☐ Birth-control medication
☐ Blood pressure medication
☐ Bowel medication
☐ Headache medication
☐ Heart-rhythm medication
☐ Herbal treatments
☐ Insulin
☐ Pain medication
☐ Psychological condition medication
☐ Seizure medication
☐ Vitamins
☐ Other (specify below)

Please provide the name, dosage, and indication for the medications you marked above. ____

____

PART THREE: IMMUNIZATIONS/TB

The following information may be required or recommended for various work settings. If not, it is optional. However, if you have official documentation of your immunization/TB history and would like it to be part of your Cornell Health record, please provide a copy to our Health Records Office (FAX: 607.255. 0269).

Hepatitis A Vaccine ☐ Havrix ☐ VAQTA

Date #1 (mm-dd-yyyy) ______________ Date #2 (mm-dd-yyyy) ______________

HEP A / HEP B Combined Vaccine

Date #1 (mm-dd-yyyy) ______________ Date #2 (mm-dd-yyyy) ______________ Date #3 (mm-dd-yyyy) ______________

Hepatitis B Vaccine Series ☐ Engerix B ☐ Recombivax-HB

Date #1 (mm-dd-yyyy) ______________ Date #2 (mm-dd-yyyy) ______________ Date #3 (mm-dd-yyyy) ______________

Human Papillomavirus (HPV) Vaccine Series *(recommended for all students 26 and under)*

Date #1 (mm-dd-yyyy) ______________ Date #2 (mm-dd-yyyy) ______________ Date #3 (mm-dd-yyyy) ______________

Meningococcal Vaccine. New York State Public Health Law requires all students to verify that they have received information about meningococcal disease and made an informed decision about immunization. Review this information at *health.cornell.edu [search "meningococcal"].*

Check all that apply.

☐ Menactra™ * Original date (mm-dd-yyyy)______________ Booster* (mm-dd-yyyy) ______________

☐ Menveo™ * Original date (mm-dd-yyyy)______________ Booster* (mm-dd-yyyy) ______________

☐ Menomune™ * Original date (mm-dd-yyyy)______________ Booster* (mm-dd-yyyy) ______________

☐ Trumenba™ *(for Type B only)* Date #1 (mm-dd-yyyy) ______________ Date #2 (mm-dd-yyyy) ______________ Date #3 (mm-dd-yyyy) ______________

☐ Bexsero™ (Type B only) *(for Type B only)* Date #1 (mm-dd-yyyy) ______________ Date #2 (mm-dd-yyyy) ______________

☐ Other meningococcal (specifiy vaccine______________________________)

Original date (mm-dd-yyyy) ______________ Booster** (mm-dd-yyyy) ______________

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Rabies Vaccine

Date #1 (mm-dd-yyyy)______________ ☐ RabAvert ☐ Imovax ☐ Unknown

Date #2 (mm-dd-yyyy)______________ ☐ RabAvert ☐ Imovax ☐ Unknown

Date #3 (mm-dd-yyyy)______________ ☐ RabAvert ☐ Imovax ☐ Unknown

Tetanus Vaccine

Booster type (TDaP, TD, or other tetanus) ______________________ Date (mm-dd-yyyy) ______________

Tuberculin (TB) Screening History **Check all tuberculin tests that apply.**

☐ PPD, Mantoux (skin tests) Date (mm-dd-yyyy)______________ Result: ________ mm of induration

☐ T-SPOT®.TB (blood test) Date (mm-dd-yyyy)______________ Result: ☐ positive ☐ negative

☐ QuantiFERON®-TB Gold (blood test) Date (mm-dd-yyyy)______________ Result: ☐ positive ☐ negative

☐ Chest Xray Date (mm-dd-yyyy) ______________ Result: ☐ normal ☐ abnormal

☐ History of treatment for Tuberculosis disease

Start Date (mm-dd-yyyy) ______________________ Duration ______________

Type of Treatment ______________________________________

☐ History of treatment for positive PPD without disease

Start Date (mm-dd-yyyy) ______________________ Duration ______________

Type of Treatment ______________________________________

Varicella (Chicken Pox). **Check all that apply.** *(If you were born in the U.S. before 1980, this requirement does not apply.)*

☐ Vaccine Date #1 (mm-dd-yyyy) ______________ Date #2 (mm-dd-yyyy) ______________

☐ Physician-diagnosed illness Date of Illness (mm-dd-yyyy) ______________

☐ Protective antibody titer Titer date (mm-dd-yyyy) ______________ Result: ☐ positive ☐ negative