DIOCESE OF WORCESTER, MASSACHUSETTS

MEDICAL HISTORY

Last Name: _____ First: _____ Middle:_____

Date of Birth: _____/_____/_____ Phone: _____ Email:_____

Emergency Contact #1: _____

Relationship: _____

Phone: _____

Emergency Contact #2: _____

Relationship: _____

Phone: _____

Physical Examination Date: _____/_____/_____ *Physician Notes Provided Upon Request*

Height_____ Weight_____ BMI_____ Pulse_____ BP_____/_____

Past Surgical History:_____

_____

Any Physical Restrictions:_____

Medications: _____

_____

Drug Allergies: _____

Food Allergies and Dietary Restrictions: _____

General Allergies: _____

	Positive	*Negative - Vaccines required*
Measles Titer Date: _____/_____/_____	❒ Immune	❒ Not Immune
Mumps Titer Date: _____/_____/_____	❒ Immune	❒ Not Immune
Rubella Titer Date: _____/_____/_____	❒ Immune	❒ Not Immune
Hepatitis B Titer Date: _____/_____/_____	❒ Immune	❒ Not Immune
Varicella Titer Date: _____/_____/_____	❒ Immune	❒ Not Immune

Healthcare Provider Signature: _____

Provider (print):_____ Date: _____/_____/_____

Address: _____

Phone: _____ Fax: _____

IMMUNIZATION RECORD

Last Name: _____ ***First:*** _____ ***Middle:*** _____

Hep B 1st Dose: ____/____/_____	Hep B 2nd Dose: ____/____/_____ *30 days from 1st dose*	Hep B 3rd Dose: ____/____/_____ *6 months from 1st dose*

Meningitis - Men ACWY ❒ MPSV4 - Menomune within the past five years _____/_____/_____

or

❒ MCV4 - Menactra or Menveo any time in the past _____/_____/_____

or

❒ Signed Waiver: _____ _____/_____/_____

Tdap within the past 10 years	_____/_____/_____

Varicella (2 doses)	1st Dose: _____/_____/_____	2nd Dose: _____/_____/_____ *1 month from 1st dose*

TB test - PPD or IGRA if high risk within the past 6 months. Date Administered: _____/_____/_____

PPD _____ mm ❒ (Pos.) or ❒ (Neg.) IGRAG ❒ (Pos.) or ❒ (Neg.)

If Positive, Chest X-Ray: _____/_____/_____ Chest X-Ray Results: ❒ (Pos.) or ❒ (Neg.)

Prophylactic Med Completed: _____/_____/_____

HPV vaccine: 1st Dose: ____/____/_____ *Required for men up to age 26.*	2nd Dose: ____/____/_____ *30 days from 1st dose*	3rd Dose: ____/____/_____ *6 months from 1st dose*

Hepatitis A: 1st Dose: ____/____/_____	2nd Dose: ____/____/_____ *6 months from 1st dose*

Influenza Vaccine: ____/____/_____

HIV Test: _____/_____/_____ ❒ (Pos.) or ❒ (Neg.)

Meningitis B and Pneumoccal vaccines are recommended for high risk groups. For those not in a high risk group, a clinical discussion with your health care provider is recommended.

Meningitis B Bexsero 1st Dose: ____/____/_____ 2nd Dose: ____/____/_____ *2 months from 1st dose*

or

Trumenba ____/____/_____ 2nd Dose: ____/____/_____ *30 days from 1st dose* 3rd Dose: ____/____/_____ *6 months from 1st dose*

Pneumococcal vaccine: _____/_____/_____

Provider Reviewed & Approved ❒ _____ *(initialed)*