

Which term are you beginning school?	STUDENT ID#
Name Last First Middle	Country of Citizenship <input type="checkbox"/> USA <input type="checkbox"/> other country, specify: _____ <input type="checkbox"/> US Resident Alien Card# _____
By what name do you wish to be addressed?	Date of Birth: Race: <input type="checkbox"/> male <input type="checkbox"/> female
Permanent address	Whom should we contact in an emergency? Name Relationship
City State Zip	Address
Primary phone number	City State Zip
Secondary phone number	Area code Phone (home)
Email address	Area code Phone (work)

MEDICAL HISTORY: Do you have a present or past history of: (check all that apply)

1-HEAD / NEUROLOGICAL

- Cerebral palsy
- Head injury/concussion
- Migraine headaches
- Multiple sclerosis
- Recurrent headaches
- Seizures
- Other _____

- Lyme disease
- Malaria
- Meningitis
- Mononucleosis
- Positive TB skin test
- Hepatitis B
- Hepatitis C
- Other _____

- Bone fracture
- Carpal tunnel syndrome
- Chronic joint injury
- Fibromyalgia
- Gout
- Herniated disk
- Recurrent ankle sprains
- Recurrent back pain
- Recurrent tendonitis
- Scoliosis
- Stress fracture
- Other _____

- Anxiety
- Bipolar disorder
- Bulimia
- Depression
- Drug addiction or abuse
- Insomnia
- Learning disability
- Obsessive compulsive disorder
- Panic attacks
- Post traumatic stress disorder
- Schizophrenia
- Sexual assault
- Social anxiety
- Other _____

2-EYES

- Blindness
- Eye trauma
- Other _____

6-CARDIO VASCULAR

- Congenital heart defect
- Heart attack
- Heart murmur
- High blood pressure
- High cholesterol
- Palpitations/Arrythmia
- Stroke
- Other _____

10-GASTROINTESTINAL

- Celiac disease
- Constipation
- Crohn's disease
- Gall bladder disease
- Hemorrhoids
- Irritable bowel syndrome
- Lactose Intolerant
- Liver disease
- Recurrent heartburn/GERD
- Ulcer
- Ulcerative colitis
- Other _____

13-BLOOD DISORDER / CANCER

- Anemia
- Blood transfusions
- Cancer
- Clotting disorder
- Leukemia
- Lymphoma
- Sickle cell disease
- Thalassemia
- Other _____

3-EAR, NOSE & THROAT

- Hearing loss
- Recurrent ear infections
- Recurrent nose bleeds
- Recurrent sinus infections
- Recurrent strep throat
- Recurrent tonsillitis
- Seasonal allergies
- TMJ problems
- Other _____

7-GYNECOLOGY

- Abnormal PAP tests
- Breast cancer
- Breast lump
- Cervical cancer
- Endometriosis
- Menstrual irregularities
- Ovarian cysts
- Pelvic Infection (PID)
- Pregnancy
- Recurrent vaginal Infections
- Other _____

11-ENDOCRINE

- Diabetes type I
- Diabetes type II
- Hyper- (overactive) thyroid
- Hypo- (low) thyroid
- Metabolic syndrome
- Obesity
- Polycystic ovarian disease
- Thyroid cancer
- Thyroid nodule
- Other _____

14-IMMUNE SYSTEM DISEASE

- Lupus
- Rheumatoid arthritis
- HIV / AIDS
- Ankylosing spondylitis
- Other _____

4-LUNGS

- Asthma
- Exercise induced asthma
- Narcolepsy
- Pneumonia
- Recurrent bronchitis
- Sleep apnea
- Other _____

8-GENITOURINARY

- Chronic kidney disease
- Impotence
- Kidney infections
- Kidney stones
- Recurrent bladder infections
- Testicular cancer
- Other _____

12-MENTAL HEALTH

- Abuse or domestic violence
- ADHD / ADD
- Alcoholism or alcohol abuse
- Anorexia

5-INFECTIONS

- Chicken pox
- Chlamydia
- Cold sores
- Genital herpes (HSV)
- Genital warts (HPV)
- Gonorrhea
- Hepatitis A
- Herpes zoster/shingles
- History of tuberculosis

9-MUSCULOSKELETAL

- Arthritis

15-DERMATOLOGY

- Acne
- Eczema
- Precancerous mole
- Psoriasis
- Recurrent hives
- Skin cancer
- Other _____

SOCIAL HISTORY

Do you now use any of the following?

- Tobacco
- Marijuana
- Other recreational drugs
- Stimulants (non-medical use)
- Other prescription drugs (non-medical use)

How often do you consume alcohol?

- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

When you drink alcohol, how much do you typically drink in one day?

- None
- 1-2 alcoholic beverages
- 3-4
- 5-6
- 7-9
- 10 or more

SPECIAL NEEDS

Do you have any special needs that we should be aware of as we support your wellbeing at OSU?

- Visual
- Hearing
- Physical
- Learning disability
- Translator (language_____)

FAMILY HISTORY

Has any close relative (parents, siblings, grandparents, aunts, uncles) ever had any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> I am adopted (history unknown) | <input type="checkbox"/> Psychological disorder | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental health problems (other) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Ovarian cancer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease/heart attack | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Hereditary disease | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cancer (other) | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |

SURGICAL/HOSPITALIZATION/ALLERGY HISTORY

Please list your surgical history: (please enter none if you have not had any surgeries in the past)

Surgery (i.e.: appendectomy, pinning of fracture, etc.)

Date

Surgery (i.e.: appendectomy, pinning of fracture, etc.)	Date

Please list any hospitalizations not included in surgical history: (please enter none if you have never been hospitalized)

Hospitalization (i.e.: emergency room, overnight stay, etc.)

Date

Hospitalization (i.e.: emergency room, overnight stay, etc.)	Date

Please list your allergy information: (please enter none if you have no known allergies)

Allergic to (include drug and non-drug allergies)

Type of reaction (rash, hives, stomach upset, etc)

Allergic to (include drug and non-drug allergies)	Type of reaction (rash, hives, stomach upset, etc)

IMMUNIZATION DOCUMENTATION FORM

- 2 doses of Measles, Mumps and Rubella (MMR) vaccination are **REQUIRED** by Oregon law and OSU
 - For additional information on OSU immunization requirements please go to <http://studenthealth.oregonstate.edu/patient-info/immunize-records>

REQUIRED VACCINES

MMR: (measles, mumps rubella combined) 2 doses required

Dose 1 ____/____/____ Dose 2 ____/____/____

➤OR<

Serological Confirmation of Immunity: Lab tests (titers) may be substituted as proof of immunity in lieu of vaccinations.

COPIES OF LAB WORK MUST BE ATTACHED

I have attached a copy of my titer results

RECOMMENDED VACCINES

Polio Date series completed (final dose given) ____/____/____

Hepatitis A

Dose 1 ____/____/____ Dose 2 ____/____/____

Hepatitis B

Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

Twinrix (Hepatitis A and Hepatitis B combined)

Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

Varicella (Chicken Pox)

Dose 1 ____/____/____ Dose 2 ____/____/____ OR date of disease ____/____/____

Tetanus-Diphtheria (Td)

Date childhood series completed: ____/____/____ most recent booster ____/____/____

Tetanus Diphtheria Pertussis(Tdap) Dose 1 ____/____/____

Meningococcal Dose 1 ____/____/____

HPV Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

Exemptions:

- I was born before January 1, 1957 (automatic exemption from MMR requirement, though a completed health form is still required)
- Medical or religious waiver requested: **you must come to Student Health Services (Immunization Compliance Office- room 103) to sign a waiver in person in order to claim the religious or medical exemption.**

Tuberculosis (TB) Screening: Students from countries identified as high risk for Tuberculosis are required to complete a TB screening upon entrance to the University. This may include a TB skin test and/or a chest x-ray. Please come to Student health Services to fulfill this requirement. Any records submitted to fulfill this requirement must be from an institution or medical office within the USA. For a current list of high risk countries, please go to <http://studenthealth.oregonstate.edu/patient-info/immunize-records> .

Health Care Provider Signature and Address:

OFFICE USE ONLY

Waiver letter/message sent
initials ____ date ____

Immunizations reviewed
initials ____ date ____

Requirements complete
initials ____ date ____

Oregon State University Student Health Services Policies

NOTIFICATION OF CHARGES: There are charges for many services at Student Health Services. Charges are generally lower than community rates. A list of common charges can be found on the SHS website at <http://studenthealth.oregonstate.edu>

NOTIFICATION OF BILLING PRACTICES: Unless other arrangements are made at the time of service, your OSU accounts will be automatically billed for services rendered. In order to keep costs low, Student Health Services does not bill private insurance companies. However, itemized receipts suitable for direct submission to insurance companies will be provided by the billing office upon request.

MEDICARE NOTIFICATION: OSU Student Health Services is not a service provider for Medicare patients.

OREGON HEALTH PLAN NOTIFICATION: OSU Student Health Services is not a primary care provider for the Oregon Health Plan (OHP). OHP patients will be held financially responsible for any and all charges incurred at Student Health Services when they are not covered by OHP. You must notify Student Health Services immediately if you have applied for the Oregon Health Plan and are attempting to receive services at Student Health Services.

CONFIDENTIALITY NOTIFICATION: Written medical records that are kept at Student Health Services are treated confidentially. If any of these records leave the campus for purposes other than treatment, they are subject to federal protection under 20 USC 1232g of the Family Educational Rights and Privacy Act. For more information visit our web site at: <http://studenthealth.oregonstate.edu>

PHOTO IDENTIFICATION NOTIFICATION: Your university photos will be incorporated into the SHS medical record for internal identification and safety purposes.

NOTIFICATION OF COLLABORATION WITH COUNSELING SERVICES: Student Health Services works collaboratively with the Counseling and Psychological Services (CAPS) on campus. Although written consent is routinely required, SHS personnel may occasionally share limited health information about you with CAPS personnel without written consent if consent is not readily obtainable and there is a significant mental health or safety concern.

NOTIFICATION OF IMMUNIZATION REQUIREMENTS: OSU policies and Oregon State law (ORS 433.234 through 433.280) and the corresponding Administrative Rules (333-19-021 through 333-19-090) require proof of a completed series of Measles, Mumps, and Rubella vaccinations. Proof of immunizations and a completed health history form must be submitted to OSU Student Health Services within the first six weeks of your first term. If this form and dates of immunization are not submitted within 6 weeks of your first date of attendance at OSU, a hold will be placed on your university account.

AUTHORIZATION FOR EMERGENCY CONTACT: Please contact the person named in the emergency contact section above (page 1 of this form) if I am being hospitalized or treated for any emergency or life-threatening medical or psychological condition and am unable to contact them myself.

I have read and understand the above notifications.

To the best of my knowledge, the health and immunization history I have given is accurate. I understand that if this form is not completed within 6 weeks after my first date of attendance at OSU, a registration hold will be placed on my university account.

Student Signature

Printed Name

Date

Student ID #