



Name: _____

Student ID Number: _____

Complete and return to:

Student Health Services
Immunization Coordinator
110 Plageman Building
Corvallis, OR 97331-8567
Phone: 541-737-7573
Medical Fax: 541-737-9665

STUDENT HEALTH HISTORY

What is your preferred name? _____

Please check your legal sex: female male

Please check your gender: female male transgender other: _____

Please check your preferred pronoun: she he other: _____

Please note: This medical history form will not be reviewed until you come to Student Health Services (SHS) for care. Please call to speak to a nurse or clinician to address any concerns or special needs.

Check any health issues you have now or have had in the past:

- | | | |
|--|--|--|
| <input type="checkbox"/> Visual impairment (not correctable) | <input type="checkbox"/> Sickle Cell disease | <input type="checkbox"/> Other chronic pain condition |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Physical disability | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Concussion | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Learning disability (not ADHD) | <input type="checkbox"/> Traumatic brain injury | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Alcoholism or alcohol abuse |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Substance addiction or abuse |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Anxiety/Panic attacks |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Palpitations/Arrhythmia | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver disease | <input type="checkbox"/> History of suicide attempt |
| <input type="checkbox"/> Clotting disorder/DVT or Thrombosis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Post-traumatic Stress Disorder (PTSD) |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Lupus | <input type="checkbox"/> Schizophrenia |
| | <input type="checkbox"/> Fibromyalgia | |

Name: _____

[Page 2 of 6]

Student ID: _____

Have you ever been diagnosed with cancer? **Check one:** **No** **Yes**

If yes, what type(s)?:

Do you have any other medical conditions or injuries not listed above? **Check one:** **No** **Yes**

If yes, please list:

Have you ever had a surgery (for example wisdom teeth removed, tonsillectomy, appendectomy, hernia repair, fracture or joint repair)? **Check one:** **No** **Yes**

If yes, please list:

Do you have any allergies to medication? **Check one:** **No** **Yes**

If yes, list name(s) of medication and type of reaction:

Have you ever had an anaphylactic or severe allergic reaction to anything other than a medication?

Check one: **No** **Yes**

If yes, list allergy(s) and type(s) of reaction: _____

Check any health problems your biological parents, grandparents or siblings have had, if known.

If you are adopted or you do not know your biological family medical history, please **check here**

- | | | |
|---|---|---|
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental health problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Colon cancer |
| <input type="checkbox"/> Heart disease/Heart attack | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Drug or alcohol addiction | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Suicide or suicide attempt | <input type="checkbox"/> Ovarian cancer |

Are there any other hereditary health problems that run in your family not listed above? **Check one:** **No** **Yes**

If yes, please list: _____

AUTHORIZATION FOR EMERGENCY CONTACT: Please contact the person named in the emergency contact section below if I am being hospitalized or treated for any emergency or life-threatening medical or psychological condition and am unable to contact them myself.

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Mobile phone: _____ Other phone: _____

Immunization Information

Please list all dates in the month/day/year format (mm/dd/yyyy)

REQUIRED VACCINES

MMR
 (Measles, Mumps, and Rubella combined): Two (2) doses **REQUIRED**

OR

Two (2) doses of Measles, two (2) doses of Mumps, and one (1) dose of Rubella **REQUIRED**

Lab tests (titers) may be substituted as proof of immunity in place of vaccinations.

Dose

1 _____

Dose

2 _____

OR

Measles

Dose

1 _____

Dose

2 _____

Mumps

Dose

1 _____

Dose

2 _____

Rubella

Dose

1 _____

Hepatitis B OR **Hepatitis A&B** (TwinRix®) Please check. Three (3) doses **REQUIRED**

Lab tests (titers) may be substituted as proof of immunity in place of vaccinations.

OR

Indicate date of disease

Dose

1 _____

Dose

2 _____

Dose

3 _____

OR

Date of disease

Tdap
 (Tetanus, Diphtheria, Pertussis): One (1) dose since 2005 **REQUIRED**

Dose

1 _____

Varicella (Chicken Pox): Two (2) doses **REQUIRED**

Lab tests (titers) may be substituted as proof of immunity in place of vaccinations.

OR

Indicate date of disease

Dose

1 _____

Dose

2 _____

OR

Date of disease

Meningococcal (MCV4 or MenACWY)
REQUIRED of all students under the age of 22. Must have received one (1) dose since turning age 16 (Menactra®, Menveo®, Menomune®).

Dose

1 _____

Meningococcal B
 Two (2) doses of Bexsero® or three (3) doses of Trumenba® **REQUIRED** of all students under age 26. This is **NOT** the same as Meningococcal MCV4 or MenACWY above.

Bexsero®

Dose

1 _____

Dose

2 _____

OR

Trumenba®

Dose

1 _____

Dose

2 _____

Dose

3 _____

Immunization Information

(continued)

RECOMMENDED VACCINES	Human Papillomavirus (HPV) Gardasil® or Gardasil®-9	Dose 1 _____ Dose 2 _____ Dose 3 _____
	Hepatitis A (Disregard if Hepatitis A&B (TwinRix®), listed above)	Dose 1 _____ Dose 2 _____

Exemptions:

- I was born before January 1, 1957 (automatic exemption from MMR and Varicella requirement).
- All students requesting a medical or non-medical waiver must come to Student Health Services in person to meet with a nurse or clinician before signing the waiver (must be done within the first three weeks of your first term).

 I have attached a copy of my immunization documentation

 I have attached a copy of my titer results

Signature of person completing form (*Parent, Student or Health Care Provider*):

Tuberculosis (TB) Screening Questionnaire

Students from countries identified as at high risk for tuberculosis (TB) or who have lived in a high-risk country for more than six (6) months are **strongly encouraged** to complete TB screening upon arrival at OSU. Please answer the following questions:

Were you born in one of countries listed below?

Yes No If yes, please **check** the country below.

Have you ever lived in one or more of the countries listed below for more than 6 months?

Yes No If yes, please **check** the country(ies) below.

-
- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Afghanistan | <input type="checkbox"/> Djibouti | <input type="checkbox"/> Malaysia | <input type="checkbox"/> Sao Tome and Principe |
| <input type="checkbox"/> Algeria | <input type="checkbox"/> Dominican Republic | <input type="checkbox"/> Maldives | <input type="checkbox"/> Senegal |
| <input type="checkbox"/> Angola | <input type="checkbox"/> Ecuador | <input type="checkbox"/> Mali | <input type="checkbox"/> Seychelles |
| <input type="checkbox"/> Anguilla | <input type="checkbox"/> El Salvador | <input type="checkbox"/> Marshall Islands | <input type="checkbox"/> Sierra Leone |
| <input type="checkbox"/> Argentina | <input type="checkbox"/> Equatorial Guinea | <input type="checkbox"/> Mauritania | <input type="checkbox"/> Singapore |
| <input type="checkbox"/> Armenia | <input type="checkbox"/> Eritrea | <input type="checkbox"/> Mauritius | <input type="checkbox"/> Solomon Islands |
| <input type="checkbox"/> Azerbaijan | <input type="checkbox"/> Ethiopia | <input type="checkbox"/> Mexico | <input type="checkbox"/> Somalia |
| <input type="checkbox"/> Bahrain | <input type="checkbox"/> Fiji | <input type="checkbox"/> Micronesia (Federated States of) | <input type="checkbox"/> South Africa |
| <input type="checkbox"/> Bahamas | <input type="checkbox"/> French Polynesia | <input type="checkbox"/> Moldova (Republic of) | <input type="checkbox"/> South Sudan |
| <input type="checkbox"/> Bangladesh | <input type="checkbox"/> Gabon | <input type="checkbox"/> Mongolia | <input type="checkbox"/> Sri Lanka |
| <input type="checkbox"/> Belarus | <input type="checkbox"/> Gambia | <input type="checkbox"/> Morocco | <input type="checkbox"/> Sudan |
| <input type="checkbox"/> Belize | <input type="checkbox"/> Georgia | <input type="checkbox"/> Mozambique | <input type="checkbox"/> Suriname |
| <input type="checkbox"/> Benin | <input type="checkbox"/> Ghana | <input type="checkbox"/> Myanmar | <input type="checkbox"/> Swaziland |
| <input type="checkbox"/> Bhutan | <input type="checkbox"/> Greenland | <input type="checkbox"/> Namibia | <input type="checkbox"/> Syria (Syrian Arab Republic) |
| <input type="checkbox"/> Bolivia (Plurinational State of) | <input type="checkbox"/> Guam | <input type="checkbox"/> Nauru | <input type="checkbox"/> Taiwan |
| <input type="checkbox"/> Bosnia and Herzegovina | <input type="checkbox"/> Guatemala | <input type="checkbox"/> Nepal | <input type="checkbox"/> Tajikistan |
| <input type="checkbox"/> Botswana | <input type="checkbox"/> Guinea | <input type="checkbox"/> Nicaragua | <input type="checkbox"/> Tanzania |
| <input type="checkbox"/> Brazil | <input type="checkbox"/> Guinea-Bissau | <input type="checkbox"/> Niger | <input type="checkbox"/> Thailand |
| <input type="checkbox"/> Brunei Darussalam | <input type="checkbox"/> Guyana | <input type="checkbox"/> Nigeria | <input type="checkbox"/> Timor-Leste |
| <input type="checkbox"/> Bulgaria | <input type="checkbox"/> Haiti | <input type="checkbox"/> Niue | <input type="checkbox"/> Togo |
| <input type="checkbox"/> Burkina Faso | <input type="checkbox"/> Honduras | <input type="checkbox"/> Northern Mariana Islands | <input type="checkbox"/> Tunisia |
| <input type="checkbox"/> Burundi | <input type="checkbox"/> India | <input type="checkbox"/> Pakistan | <input type="checkbox"/> Turkey |
| <input type="checkbox"/> Cambodia | <input type="checkbox"/> Indonesia | <input type="checkbox"/> Palau | <input type="checkbox"/> Turkmenistan |
| <input type="checkbox"/> Cameroon | <input type="checkbox"/> Iraq | <input type="checkbox"/> Panama | <input type="checkbox"/> Tuvalu |
| <input type="checkbox"/> Cape Verde | <input type="checkbox"/> Kazakhstan | <input type="checkbox"/> Papua New Guinea | <input type="checkbox"/> Uganda |
| <input type="checkbox"/> Central African Republic | <input type="checkbox"/> Kenya | <input type="checkbox"/> Paraguay | <input type="checkbox"/> Ukraine |
| <input type="checkbox"/> Chad | <input type="checkbox"/> Kiribati | <input type="checkbox"/> Peru | <input type="checkbox"/> United Republic of Tanzania |
| <input type="checkbox"/> China | <input type="checkbox"/> Korea (Republic of) | <input type="checkbox"/> Philippines | <input type="checkbox"/> Uruguay |
| <input type="checkbox"/> China, Hong Kong SAR | <input type="checkbox"/> Kuwait | <input type="checkbox"/> Portugal | <input type="checkbox"/> Uzbekistan |
| <input type="checkbox"/> China, Macao SAR | <input type="checkbox"/> Kyrgyzstan | <input type="checkbox"/> Qatar | <input type="checkbox"/> Vanuatu |
| <input type="checkbox"/> Colombia | <input type="checkbox"/> Lao People's Democratic Republic | <input type="checkbox"/> Republic of Korea | <input type="checkbox"/> Venezuela (Bolivarian Republic) |
| <input type="checkbox"/> Comoros | <input type="checkbox"/> Latvia | <input type="checkbox"/> Republic of Moldova | <input type="checkbox"/> Viet Nam |
| <input type="checkbox"/> Congo | <input type="checkbox"/> Lesotho | <input type="checkbox"/> Romania | <input type="checkbox"/> Yemen |
| <input type="checkbox"/> Côte d'Ivoire | <input type="checkbox"/> Liberia | <input type="checkbox"/> Russian Federation | <input type="checkbox"/> Zambia |
| <input type="checkbox"/> Dem People's Republic of Korea | <input type="checkbox"/> Libya | <input type="checkbox"/> Rwanda | <input type="checkbox"/> Zimbabwe |
| <input type="checkbox"/> Democratic Republic of the Congo | <input type="checkbox"/> Lithuania | <input type="checkbox"/> Saint Vincent and the Grenadines | |
| | <input type="checkbox"/> Madagascar | | |
| | <input type="checkbox"/> Malawi | | |

Source: World Health Organization estimates of tuberculosis incidence by country, 2016. Countries with rates of ≥ 20 cases per 100,000 population.

If you answered **YES** to either of the questions above, we **strongly recommend** that you have a TB screening within the USA. Please call 541-737-7573 for more information.

If you answered **NO** to the above questions, no TB screening is required or recommended.

Notification of Student Health Services Policies

PRIVACY AND CONFIDENTIALITY

With a student's consent, Student Health Services may disclose information for the purposes of providing medical treatment and bill the student's insurance company for services and treatment received. In some circumstances Student Health Services providers may need to disclose health information without a student's written consent:

- If necessary to protect the health and safety of the student or others;
- As a result of a court order or subpoena;
- To verify to the university whether the student has completed all mandatory immunizations;
- Other instances required by law; for example, certain communicable diseases must be reported to the Benton County Health Department.

For more detail regarding confidentiality notification please consult: <http://studenthealth.oregonstate.edu/general/policies-and-guidelines/privacy-and-confidentiality>.

IMMUNIZATION REQUIREMENTS

OSU policies, Oregon State law (ORS 433.282 and 433.284) and the corresponding Administrative Rules (333-050-0130) require a completed series of Measles, Mumps, and Rubella (MMR) vaccinations. Along with the MMR vaccination, OSU polices also require Quadrivalent Meningococcal (MCV4), Meningococcal B, Hepatitis B, Tdap, and Varicella. For complete immunization information please refer to <http://studenthealth.oregonstate.edu/general/policies-and-guidelines/immunizations-tb-screening-and-health-history>. Immunization records 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 registration hold will be placed on your university account.**

RIGHTS AND RESPONSIBILITIES

Patients have the right to impartial access to treatment or accommodations that are available or medically necessary. Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to their health. For more detail regarding rights and responsibilities, please see: <http://studenthealth.oregonstate.edu/general/policies-and-guidelines/rights-and-responsibilities>.

CHARGES

There are charges for a number of services at Student Health Services, such as lab tests, x-rays, and immunizations. A list of common charges can be found at: <http://studenthealth.oregonstate.edu/general/fees-services/most-common-fees>.

BILLING PRACTICES

Students presenting to SHS should bring their current insurance card and picture ID.

- For student sponsored Aetna and Pacific Source Plans: We are 'in network' and will directly bill the insurance company. Your student account will only be billed for what is not covered by insurance.
- For all other insurance plans: We bill any 'out of network' plan as a courtesy. The charges will first be applied to your student account. The insurance company may pay you directly, or if the company pays SHS directly we will subtract that amount from your student account.
- For OSU Student Employee Worker's Comp and Motor Vehicle Accidents: We will directly bill and accept payment in full from the covering insurance agency.

OREGON HEALTH PLAN

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.

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

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

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 # _____