Oregon State University

Student Health Services
108 SW Memorial Place
Corvallis, OR 97331

Name: _____

ID #: _____

INTERNATIONAL STUDENT HEALTH HISTORY

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.

Complete and return to:
Student Health Services Immunization Office
110 Plageman Building, 108 SW Memorial Place
Corvallis, OR 97331-8567

phone: 541-737-7573
fax: 541-737-9665
email: immunizations@oregonstate.edu
(Not secure; for general questions only)
patient portal: myhealth.oregonstate.edu *(Secure; log in with ID)*

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

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

 Name: _____ Student ID Number: _____

1. Have you ever been diagnosed with cancer?	**Check one:** ☐ No ☐ Yes	If yes, what type(s)?
2. Do you have any other medical conditions or injuries not listed above?	**Check one:** ☐ No ☐ Yes	If yes, please list:
3. 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:
4. Do you have any allergies to medication?	**Check one:** ☐ No ☐ Yes	If yes, list name(s) of medication and type of reaction:
5. 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:

6. **Check** any health problems your biological parents, grandparents or siblings have had, if known.	☐ Blood clots	☐ High cholesterol	☐ Drug or alcohol addiction	☐ Melanoma
	☐ Stroke	☐ Diabetes	☐ Suicide or suicide attempt	☐ Breast cancer
If you are adopted or you do not know your biological family medical history, please ☐ **check here**	☐ Heart disease /Heart attack	☐ Kidney disease	☐ Mental health problems	☐ Ovarian cancer
	☐ High blood pressure	☐ Thyroid disorder	☐ Colon cancer	
7. 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		City, State Zip	
Cell phone		Other phone	

If you complete this form electronically, please rename it and save it before printing.

 Name: _____ Student ID Number: _____

IMMUNIZATION HISTORY

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

	REQUIRED of All Students	Date		
	Vaccine	**Dose 1**	**Dose 2**	**Dose 3**
A	☐ MMR/Measles, Mumps and Rubella combined (2 doses) or			
	☐ Measles (2 doses) and			
	☐ Mumps (2 doses) and			
	☐ Rubella (1 dose)			
	Note: Lab tests (titers) may be substituted as proof of immunity in place of vaccinations			
B	Hepatitis B			
	☐ Engerix B® or Recombivax HB® (3 doses) or			
	☐ Heplisav-B® (2 doses) or			
	☐ TwinRix A/B® (3 doses) or			
	☐ Date of disease: _____ *Note: Lab tests (titers) may be substituted as proof of immunity in place of vaccinations*			
C	☐ Tdap (Tetanus, Diphtheria, Pertussis) – one dose within last 10 years			
D	☐ Varicella/Chickenpox (2 doses) or			
	☐ Date of disease: _____ *Note: Lab tests (titers) may be substituted as proof of immunity in place of vaccinations*			
	REQUIRED of Students Age 21 or Younger Only			
E	☐ Meningococcal (MenACYW or MCV4) – Must have received one dose since turning age 16 (Menactra, Menveo or Menomune)			
	RECOMMENDED but not Required			
F	Meningococcal B – recommended for students under age 26 (Note that this is different than the required Meningococcal ACYW/MCV4)			
	☐ Bexsero® (2 doses) or			
	☐ Trumenba® (2 doses; 3 doses recommended if at an increased risk)			
G	☐ Hepatitis A (2 doses) – disregard if Hepatitis A&B/TwinRix was received			
H	☐ Human Papillomavirus (HBV) – Gardasil® or Gardasil -9® (3 doses)			

Exemptions: All students requesting a waiver (medical or non-medical) must meet with a clinician at Student Health Services before signing a waiver. This must be done within the first 3 weeks of the student's first term at Oregon State University.

☐ I was born before January 1, 1957 (automatic exemption from MMR and Varicella requirements).

☐ I have attached a copy of my immunization documentation.

☐ I have attached a copy of my titer result(s).

_____ _____

Signature of person completing form (Student, Parent or Guardian) **Signature** of Healthcare Provider

 Name: _____ Student ID Number: _____

TUBERCULOSIS (TB) SCREENING QUESTIONNNAIRE

1. Have you ever had close contact with persons known or suspected to have active TB disease? **Please check ☐ No ☐ Yes**
2. Were you born in one of the countries listed below that have a high incidence of active TB disease? **Please check ☐ No ☐ Yes**
   If yes: Please select the country below. A TB test is required.

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

Source: World Health Organization estimates of Tuberculosis incidence by country, 2017. Countries with rates of ≥ 20 cases per 100,000 population.

3. Have you had frequent or prolonged visits to one or more of the countries listed above with a high incidence of TB disease?
   Please check ☐ No ☐ Yes If yes, check the countries above. A TB test is required.
4. Have you been a resident/employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, or homeless shelters?
   Please check ☐ No ☐ Yes
5. Have you been a volunteer or health care worker who served clients who were at increased risk for active TB disease?
   Please check ☐ No ☐ Yes
6. Have you ever been a member of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: Medically underserved, low income or abusing drugs or alcohol? **Please check ☐ No ☐ Yes**

 Name: _____ Student ID Number: _____

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/rights-and-responsibilities.

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, Oregon State University polices also require Quadrivalent Meningococcal (MCV4), Hepatitis B, Tdap, and Varicella. For complete immunization information please refer to http://studenthealth.oregonstate.edu/immunizations. Immunization records and a completed health history form must be submitted to Student Health Services within the first six weeks of your first term. If this information is not submitted within 6 weeks of your first date of attendance at Oregon State, a registration hold will be placed on your university account. We strongly advise that students obtain all required immunizations prior to arrival on campus.

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.

BILLING PRACTICES

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

- For university-sponsored PacificSource 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

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 us immediately if you have applied for the Oregon Health Plan and are attempting to receive services at Student Health Services.

MEDICARE: 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 Oregon State, a registration hold will be placed on my university account.

Student Signature _____ Printed name _____

Student ID number _____ Date _____