

Montana State University - Billings

Health History Form

International Studies Office
Montana State University-Billings
Billings, MT. 59101
Tel (406) 657-1705
Fax (406) 657-2299

Student Health Service
Montana State University-Billings
Billings, MT. 59101
Tel (406) 657-2153
Fax (406) 657-2145

You must have a completed health questionnaire and **physician-validated immunization record** to complete your admission to Montana State University. Please return this to the International Studies Office. This information is strictly for the use of the Health Service and will not be released to anyone without your written consent.

MUST BE ON FILE BEFORE ORIENTATION/REGISTRATION

IDENTIFICATION – PLEASE PRINT OR TYPE

NAME _____ Soc Sec No. _____
last first middle

Present address _____

Telephone: Daytime (_____) Evening(_____) Sex: Male () Female() Birthday ___/___/___

Father's name _____ Mother's name _____

HEALTH CARE

Name and address of your primary physician or other health care provider (if any)

Name _____ Degree _____ Phone _____

Address _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____ Relationship _____

Address _____

Home telephone (_____) _____ Work telephone (_____) _____

Immunization Requirements For Attending MSU- Billings

The following immunizations are either required or recommended by state law or MSU policy. This information **must** be from your Physician's records or other official immunization records and signed by a nurse or physician.

REQUIRED

A. MMR (Measles, Mumps, Rubella) (Required). Two MMR immunizations: both after 12 months of age, the second after 1980. This meets requirements for Measles, Mumps and Rubella (B, C, and D), below. (Any before 1968 are not considered adequate) **or**

B. Measles (Rubeola) (Required). Student complies if:

1. Student had Measles (Rubeola) confirmed by medical record **or**
2. Student received two immunizations: one after 12 months of age, the second after 1980 **or**
3. Student was born before January 1957.

C. Rubella (German Measles) (Required). Student complies if:

1. Student has report of immune titer proving immunity **or**
2. Student received two immunizations: one after 12 months of age, the second after 1980 **or**
3. Student was born before January 1957.

D. Mumps (Required). Student complies if:

1. Student had Mumps as confirmed by medical record **or**
2. Student received two immunizations: one after 12 months of age, the second after 1980 **or**
3. Student was born before January 1957.

E. Tetanus and Diphtheria (Required). Student complies if she or he has current vaccination against Tetanus and Diphtheria (within 10 years prior to the day your classes begin)

F. Tuberculosis Skin Test (Required). Student should have a current skin test for Tuberculosis (within 12 months prior to 1st day of classes). PPD preferred.

Note: If BCG was given, please list date.

If you had a X-ray within last year, please list date and results.

MMR (mo./day/year)

Date of 1st MMR _____

Date of 2nd MMR _____

Rubeola (mo./day/year)

Date of rubeola disease _____ or

Date of 1st vaccination _____

Date of 2nd vaccination _____

Rubella (mo./day/year)

Date of immune titer _____ or

Date of 1st vaccination _____

Date of 2nd vaccination _____

Mumps (mo./day/year)

Date of Mumps disease _____ or

Date of 1st vaccination _____

Date of 2nd vaccination _____

Tetanus/Diphtheria (mo./day/year)

Date of booster _____

Tuberculosis (mo./day/year)

Date of PPD _____

PPD results _____ mm or

Date of BCG _____ or

Date of X-ray _____

X-ray results _____

Hepatitis B

Dates: 1st _____ 2nd _____

3rd _____

Polio

Date series completed _____

RECOMMENDED

G. Hepatitis B

H. Polio. Student complies if primary series completed (2 oral Polio or 3 intramuscular vaccinations).

Nurse's or
Physician's name _____ Signature _____ Date _____

Address _____ Phone number _____

We will gladly accept a copy of your records as proof of vaccination, but please include your full name (as if appears on your MSU-B application), and **your mailing address** when you send it to us.

FAMILY MEDICAL HISTORY

If **any** of your blood relatives had the diseases listed, check in the space provided (including parents, siblings, children).

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hereditary disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma or hay fever | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> other (specify) _____ |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Emotional | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Migraine | Are you adopted? |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> No |

PERSONAL HISTORY—Have you had or are you now under treatment for any of the following problems:

- | | | |
|---|---|---|
| <input type="checkbox"/> Congenital or hereditary disorders | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Extreme weight loss or gain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Protein in urine |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other genital problems |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Other respiratory problems | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic heart diseases | <input type="checkbox"/> Extremity injury |
| <input type="checkbox"/> Meningitis/encephalitis | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Other bone or joint problems |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other heart/circulatory problems | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Other skin problems |
| <input type="checkbox"/> Sore throat/tonsillitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Easy bruisability |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Color blind | <input type="checkbox"/> Chronic diarrhea/constipation | <input type="checkbox"/> Other hormone/Blood problems |
| <input type="checkbox"/> Other ear, nose, throat problems | <input type="checkbox"/> Rectal problems | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Other digestive diseases | |

WOMEN ONLY

- | | | |
|---|--|--|
| <input type="checkbox"/> Excessive menstrual flow | <input type="checkbox"/> Pregnancy # _____ | <input type="checkbox"/> Toxic shock |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Amenorrhea (no periods) # _____ | <input type="checkbox"/> Abnormal Pap (date) _____ |
| <input type="checkbox"/> Severe menstrual cramps | <input type="checkbox"/> Pelvic infection | <input type="checkbox"/> Other (specify) _____ |

DRUG ALLERGIES

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other antibiotic (specify) _____ | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Penicillin | _____ | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Sulfa | _____ | _____ |

SURGICAL OPERATIONS

- | | | |
|--|---|--|
| <input type="checkbox"/> Mole removal | <input type="checkbox"/> Tonsils/adenoids | <input type="checkbox"/> Gynecological surgery |
| <input type="checkbox"/> Breast diopsy | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Other surgery (specify) _____ |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Orthopedic surgery | _____ |

HOSPITALIZATION FOR MEDICAL REASONS

MEDICATIONS (used frequently or regularly)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergy shots | <input type="checkbox"/> Bowel medications | <input type="checkbox"/> Iron |
| <input type="checkbox"/> Antacid | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Pain medication |
| <input type="checkbox"/> Antibiotic | <input type="checkbox"/> Epilepsy medication | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Antidepressant | <input type="checkbox"/> Headache medication | <input type="checkbox"/> Thyroid hormone |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Heart rhythm medication | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Asthma medications | <input type="checkbox"/> Insulin | <input type="checkbox"/> Other (specify) _____ |

MISCELLANEOUS HISTORY

- Have you ever interrupted school because physical illness?..... Yes No
- Have interrupted school because of an emotional illness?..... Yes No
- Did you ever have radiation treatment? Yes No
- Did your mother take DES (diethylstilbestrol) when pregnant with you? Yes No
- Have you ever had significant exposure to hazardous substances
(i.e. asbestos, benzene, lead, pesticides, etc.)? Yes No
- Do you smoke cigarettes? Yes No
- Do you use smokeless tobacco? Yes No
- Have you ever had problem with alcohol? Yes No
- Do you use seatbelts regularly? Yes No
- What is your desired weight? Yes No
- What is your current weight? _____ lbs and height? _____ ft _____ inches

DISABILITY

- | | | |
|-------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Other motor | <input type="checkbox"/> other |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Emotional | _____ |
| <input type="checkbox"/> Locomotion | <input type="checkbox"/> Learning | _____ |

IF you have any problems that you want to discuss with a staff physician, please call and make an appointment.