Montana State University – Bozeman
Health History Form

Student Health Service
Montana State University
Bozeman MT 59717
Telephone 406-994-2311
FAX # 406-994-2504

You must have a completed health questionnaire and **physician-validated immunization record** to complete your admission to Montana State University. **The completed forms must be returned before orientation/registration** to the Student Health Service. 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 _____
last first middle

Name you prefer to be called _____ Soc Sec No _____

Present address _____
Street City State Zip

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_____
M.D., D.O., R.N., etc.

Address _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name_____Relationship _____

Address _____

Home telephone (_____) _____Work telephone (_____) _____

Immunization Requirements For Attending MSU

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. **Deadline: One week before attending your scheduled Orientation Program.**

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 after1980 **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). Students 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 complies if he/she has had a current tuberculosis test within 12 months prior to 1st day of classes. PPD preferred.

RECOMMENDED

G. Hepatitis B

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

I. Meningococcal Meningitis Vaccine

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 on 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 Td booster _____

Tuberculosis (mo/day/year)
Date of PPD _____
PPD results _____mm or

Hepatitis B (mo/day/year)
Dates1st: _____2nd _____3rd _____

Polio Date series completed _____

Meningitis Date given _____

Nurse's or
Physician's name _____Signature _____Date _____

Address _____Phone number _____

Your high school, private physician, or city health department may be able to help you find proof of your vaccinations. We will gladly accept a copy of your records as proof of vaccination, but please include your full name (as it appears on your MSU application, **your social security number,** and **your mailing address** when you send it to us. Religious or medical exemptions can be granted if appropriate.)

FAMILY MEDICAL HISTORY
If any of your blood relatives had the diseases listed, check in the space provided (includes parents, siblings, children).

_____Alcohol
_____Anemia
_____Asthma or hay fever
_____Bleeding tendency
_____Cancer (type) _____
_____Diabetes
_____Heart Disease
_____Hereditary disorder
_____High blood pressure
_____Emotional
_____Migraine
_____Epilepsy or seizures
_____Stroke
_____Tuberculosis
_____Other (specify)
_____Are you adopted?
_____Yes
_____No

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

_____Congenital or hereditary disorders
_____Extreme weight loss or gain
_____Sleep disturbance
_____Eating disorder
_____Night sweats
_____Cancer (type) _____
_____Severe headaches
_____Seizures
_____Meningitis/encephalitis
_____Loss of consciousness
_____Frequent ear infections
_____Dizziness
_____Frequent colds
_____Sore throats/tonsillitis
_____Glasses/contacts
_____Nose bleeds
_____Color blind
_____Other ear, nose, throat problems
_____Chronic cough
_____Pneumonia
_____Asthma
_____Hay fever
_____Shortness of breath
_____Tuberculosis
_____Other respiratory problems
_____Heart murmur
_____Rheumatic heart disease
_____Palpitations
_____High blood pressure
_____Other heart or circulatory problems
_____Jaundice
_____Hepatitis
_____Ulcer
_____Abdominal pain
_____Chronic diarrhea/constipation
_____Rectal problems
_____Other digestive diseases
_____Urinary tract infections
_____Kidney Stones
_____Protein in urine
_____Sexually transmitted disease/herpes
_____Hernia
_____Other genital problems
_____Back pain
_____Joint pain
_____Extremity injury
_____Other bone or joint problems
_____Acne
_____Eczema
_____Other skin problems
_____Diabetes
_____Easy bruising or bleeding tendency
_____Anemia
_____Thyroid disorder
_____Hormone or blood problems
_____Emotional problems

WOMEN ONLY _____

_____Excessive menstrual flow
_____Irregular periods
_____Severe menstrual cramps
_____Pregnancy #_____
_____Amenorrhea (no periods) # __
_____Pelvic infection
_____Toxic Shock
_____Abnormal Pap (date) _____
_____Other (Specify) _____

DRUG ALLERGIES _____

_____Aspirin
_____Penicillin
_____Sulfa
_____Other antibiotic (specify) ____
_____
_____
_____Codeine
_____Other (specify) _____
_____ _____

SURGICAL OPERATIONS _____

_____Mole removal
_____Breast diopsy
_____Appendectomy
_____Tonsils/adenoids
_____Thyroid
_____Orthopedic surgery
_____Gynecological surgery
_____Other surgical (specify)
_____ _____

HOSPITALIZATION FOR MEDICAL REASONS _____
_____
_____

MEDICATIONS (used frequently or regularly) _____

_____Allergy shots
_____Antacid
_____Antibiotic
_____Antidepressant
_____Antihistamine
_____Asthma medications
_____Bowel medications
_____Birth control pills
_____Epilepsy medication
_____Headache medication
_____Heart rhythm medication
_____Insulin
_____Iron
_____Pain medication
_____Sleeping pills
_____Thyroid hormone
_____Tranquilizers
_____Other (specify)

MISCELLANEOUS HISTORY _____

_____Have you ever interrupted school because of a physical illness? ..... _____Yes ____No
_____Have you interrupted school because of an emotional illness? ..... _____Yes ____No
_____Did you ever have radiation treatment? ..... _____Yes ____No
_____Did your mother take DES (diethylstibestrol) 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 problems 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 _____

_____Vision
_____Hearing
_____Locomotion
_____Other motor
_____Emotional
_____Learning
_____Other
_____
_____

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