

## Health History Form – Must be returned to the University Health Center

Complete each section and sign at the bottom of page 4. Return to the University Health Center at least 45 days prior to the start of classes.

### UP-issued Student ID#

I will be entering as  Undergraduate  Graduate  Beginning  Fall  Spring  Summer semester

I am a student in  Arts & Sciences  Education  Business  Engineering  Undecided  Nursing

Have you previously attended the University of Portland?  Yes  No If yes, what year?

If yes, you still need to complete this form to update information.

Name  Cell phone   
LAST (PLEASE PRINT) FIRST MIDDLE

Permanent address   
STREET AND NUMBER

CITY STATE ZIP

Date of birth:  /  /  Sex:  Male  Female  
MONTH DAY YEAR

Whom should we contact in an emergency?

NAME/RELATIONSHIP DAY PHONE HOME OR CELL PHONE

**If you require an accommodation for a disability in order to fully participate in any class or program of the University of Portland, including housing, contact the Office for Students with Disabilities: (503) 943-7134 (voice). Please note you must submit your Residence Life (housing) accommodation request and documentation no later than May 1 for Fall semester, October 1 for Spring semester.**

### Please answer questions below:

Are you allergic to any medications?  Yes  No

If yes, specify:

Have you taken any prescription medicines for a chronic condition the past year?  Yes  No

If yes, specify:

Do you use needles or syringes for medical reasons?  Yes  No

If yes, specify:

If yes, you should discuss the proper disposal of these items with the Health Center.

### Medical Insurance Information

Medical Insurance:  Yes  No Company:  Policy #:  Group #:

**We encourage you to carry a copy of your current insurance card.**

Note: If your current coverage is not effective in the Portland area, you may want to inquire about the insurance available through the University.

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

**Have you (student) ever had any of the following?**

- |   |  |  |  |
|---|--|--|--|
| 1. Surgery/hospitalizations   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Asthma                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Blood disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Cancer                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Immune Deficiency  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Other medical problems                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Heart problems   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Eating Disorder                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Stomach/gastrointestinal problems                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Depression                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Chronic bladder/kidney problems                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Anxiety                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Disorders of menstrual periods,<br>reproductive organs, or breasts | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Drug/alcohol concerns                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Pelvic exam/pap smear  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Use of tobacco products                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 20. Other mental health problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 21. Relationship difficulties                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 22. Self-concept concerns                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 23. Test taking anxiety                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 24. Time management difficulties             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 25. Allergies (i.e. bee stings, latex, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, date of last exam \_\_\_\_\_

- |                       |  |
|-----------------------|--|
| 9. Diabetes           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Thyroid problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Epilepsy/seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please specify \_\_\_\_\_

**If you answered yes to any of the above, please give details here (identify by number)**

**Family health history: grandparents, parents, siblings**

Unknown (i.e. adopted)

Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Peptic ulcer disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Blood disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Alcohol or drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Mental health problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

**Immunization Information**

Immunization records may generally be obtained from your family physician or nurse practitioner, last high school or college attended, military records, or your parents.

**REQUIRED IMMUNIZATIONS – ALL STUDENTS**

Oregon state law <b>requires</b> that each entering full-time student born on or after January 1, 1957 must have two doses of measles vaccine or MMR vaccine (documented by month and year of each dose) on or after the first birthday, with a minimum of 30 days between doses.			
<b>MMR Measles, mumps, rubella</b>	MMR First Dose (month/day/year)	MMR Second Dose (month/day/year)	
	<input type="checkbox"/> Age exempt		(born before 1957 and considered immune)
	<input type="checkbox"/> Religious exemption		Please request religious exemption from the University Health Center
	<input type="checkbox"/> Medical exemption based on:	<input type="checkbox"/> History of measles, mumps and/or rubella (month/year) <input type="checkbox"/> Immune Titer laboratory test which shows immunity <input type="checkbox"/> Other (specify)	Attach copy of documentation Attach documentation

**RECOMMENDED IMMUNIZATIONS – ALL STUDENTS**

**Meningococcal Meningitis Vaccine:** The American College Health Association recommends all students consider this vaccination. Your health provider or the University Health Center can provide more information.

Date of Immunization (month/day/year): \_\_\_\_\_

**Varicella Vaccine:** All students who have not had chickenpox, or the vaccine, or students with a negative antibody titer (blood test) should strongly consider this vaccine. Your health provider or the University Health Center can provide more information.

Date of immunization of disease (month/day/year): \_\_\_\_\_

**\*\*\*\*\* We encourage you to enclose a copy of all immunization records.\*\*\*\*\***

**MANDATORY TEST FOR INTERNATIONAL STUDENTS**

**Tuberculosis Evaluation**

Initial Evaluation consists of a ppd skin test; for those students with positive ppds, a chest c-ray and health evaluation is also necessary. If you have ever had a previous positive ppd skin test, you need a chest x-ray and/or health evaluation.

**Note for International Students: this must be done by a United States health care provider.**

**Step 1**

Date PPD given \_\_\_\_\_ Time given \_\_\_\_\_

Signature of U.S. health care provider \_\_\_\_\_

Date read \_\_\_\_\_ Time read \_\_\_\_\_

Results (mm induration) \_\_\_\_\_  Positive  Negative

**Step 2**

**Complete this step if your test result is positive now, or if you have ever had a positive result.**

Date of chest x-ray \_\_\_\_\_ Results \_\_\_\_\_

Date of medical evaluation \_\_\_\_\_ Student  Is  Is not free of active TB

Signature of U.S. health care provider \_\_\_\_\_ Time read \_\_\_\_\_

Was prophylactic medication advised?  Yes  No Date started \_\_\_\_\_ Date finished \_\_\_\_\_

Reasons for declining treatment for positive PPD? \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Although the University of Portland does not require tuberculosis evaluation of other students, **it strongly encourages testing for the following groups of students:**

■ **Students with other risk factors for TB, including:**

- HIV infection or risk factors for HIV
- Close contact with a person with infectious TB
- Injection drug use
- Residence in long-term care facilities
- Certain medical conditions (silicosis, steroid therapy, diabetes mellitus, low body weight, chronic malabsorption syndromes, or history of leukemia, Hodgkins disease, or cancer of head or neck)

■ **Students with symptoms suggestive of TB:**

- Productive cough of more than three weeks
- Coughing up blood
- Prolonged and unexplained fevers, nightsweats, or involuntary weight loss

■ **Students who have spent six months or more outside this country.**

This includes domestic students who travel or have traveled outside the country for six months or more, and international students who return home for an extended period of time.

**I verify that the Health History Information submitted is true and accurate to the best of my knowledge. If a School of Nursing student, my signature below also authorizes the Health Center to notify the School of Nursing of my immunization status.**

Student's signature \_\_\_\_\_ Date \_\_\_\_\_

Student's name (please print) \_\_\_\_\_

**Note: This form is required even though you may have a separate physical exam form to be completed for another department on campus. This form must be returned to the Health Center.**