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/REGISTRATRION

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.

RECOMMENDED

G. Hepatitis B

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

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 _____

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).

____Alcohol
____Anemia
____Asthma or hay lever
____Bleeding tendency
____Cancer (type)_____
____Diabetes
____Heart disease
____Hereditary disorder
____High blood pressure
____Emotional
____Migraine
____Epilepsy or seizures
____Stroke
____Tuberculosis
____other (specify)_____
____Yes
Are you adopted?
____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
____Dizziness
____Frequent colds
____Sore throat/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 diseases
____Palpitations
____High blood pressure
____Other heart/circulatory problems
____Jaundice
____Hepatitis
____Ulcer
____Abdominal pain
____Chronic diarrhea/constipation
____Rectal problems
____Other digestive diseases
____Urinary tract infections
____Protein in urine
____Sexually transmitted disease
____Hernia
____Other genital problems
____Back pain
____Joint pain
____Extremity injury
____Other bone or joint problems
____Acne
____Eczema
____Other skin problems
____Diabetes
____Easy bruisability
____Anemia
____Other hormone/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 surgery (specify)_____
_____

HOSPITALIZATION FOR MEDICAL REASONS_____

_____

_____

MEDICATIONS (used frequently or regularly)_____

____Allergy shots
____Antacid
____Antibiotic
____Antidepressant
____Antihistamines
____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 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 you desired weight? ..... ____Yes ____No
____What is your current weight? _____lbs and height? _____ft _____inches

DISABILITY_____

____Vision	____Other motor	____other
____Hearing	____Emotional	_____
____Locomotion	____Learning	_____

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