UNIVERSITY OF SCIENCE & ARTS OF OKLAHOMA

STUDENT MEDICAL HISTORY | INTERNATIONAL STUDENTS

STUDENT NAME _____
LAST NAME FIRST NAME MIDDLE NAME

DATE OF BIRTH_____ AGE_____ SEX_____

The following medical history will alert the Health Center of any diseases or problems needing follow-up care and will serve as a valuable reference in the event of illness or injury. The information on this form is confidential and is retained in your file for use by Science & Arts Health Services only. Information obtained on this form may be released only upon your written consent.

1. Have you ever had or have you now any serious medical illness(es)? YES____ NO____

   If yes, please list illness(es) and age of occurrence _____

   _____

2. Have you ever been hospitalized? YES____ NO____

   If yes, please list reason and dates of hospitalization _____

   _____

3. Have you ever had any surgeries? YES____ NO____

   If yes, please list reason and date of surgeries _____

   _____

4. Are you currently taking any medications regularly? YES____ NO____

   If yes, please list medications, dosage, and frequency (times per day, date you started taking medication)

   _____

   _____

5. Are you allergic (hives/whelps) or sensitive (nausea/vomiting) to any medications or foods? YES____ NO____

   If yes, please list medications and foods _____

   _____

Oklahoma Statutes, Title 70 sec. 3244 requires all students who enroll as a full-time student in an Oklahoma public or private postsecondary institution to provide documentation of vaccinations against Hepatitis B (three doses) and MMR-measles, mumps, and rubella (two doses).

THIS SECTION IS TO BE COMPLETED BY A PHYSICIAN

REQUIRED IMMUNIZATIONS

MMR

MMR (Measles, Mumps, Rubella)

Dose 1 (not immunized prior to first birthday and after 1971) Date ____ /____ /_____
Dose 2 (immunized as above and at least 28 days after the first dose) Date ____ /____ /_____

Or

Measles – Two doses at least 28 days apart, given no more than four days prior to the first birthday and after 1967

Dose 1 (immunized on or after January 1, 1968) Date ____ /____ /_____
Dose 2 (immunized as above and at least 28 days after the first dose) Date ____ /____ /_____
Mumps – one dose after January 1, 1968 Date ____ /____ /_____
Rubella – one dose after January 1, 1968 Date ____ /____ /_____
Or

Serologic evidence of immunity for each disease – Laboratory report verifying immunity (IgG) to measles, mumps and rubella are required (titers).
LAB REPORTS MUST BE ATTACHED

HEPATITIS B

Hepatitis B Dose #1 ____ /____ /_____ Dose #2 ____ /____ /_____ Dose #3 ____ /____ /_____

MENINGOCOCCAL (Required only if living in on-campus housing)

Meningococcal Conjugate Vaccine – students between the ages of 16-21 must have one dose of Menactra, Menveo, Nimenrix or Aramen on or after their 16th birthday. Students aged 22 and over are not required to receive the vaccine. **Meningococcal-B vaccine does not meet this requirement.**

Vaccine name: _____ Date ____ /____ /_____

RECOMMENDED IMMUNIZATIONS – complete if received

Hepatitis A	Dose #1 ____ /____ /_____	Dose #2 ____ /____ /_____	
HPV (Gardasil)	Dose #1 ____ /____ /_____	Dose #2 ____ /____ /_____	Dose #3 ____ /____ /_____
Meningococcal Type B	Dose #1 ____ /____ /_____ Bexsero Trumenba	Dose #2 ____ /____ /_____ Bexsero Trumenba	Dose #3 ____ /____ /_____ Bexsero Trumenba
Meningococcal ACYW135	Dose #1 ____ /____ /_____	Dose #2 ____ /____ /_____	Dose #3 ____ /____ /_____
Tdap (Tetanus, Diphtheria, Pertussis) *or* Tetanus Toxoid (Within 10 years)	Date ____ /____ /_____		

CONTINUED ON NEXT PAGE

RECOMMENDED IMMUNIZATIONS – complete if received (continued)

Polio (oral)	Dose #1 ____ /____ /_____	Dose #2 ____ /____ /_____	Dose #3 ____ /____ /_____
Typhoid (subsequent immunization dates)	Dose #1 ____ /____ /_____	Dose #2 ____ /____ /_____	Dose #3 ____ /____ /_____
Varicella	Dose #1 ____ /____ /_____	Dose #2 ____ /____ /_____	Had Varicella (chickenpox)
COVID-19	Pfizer Moderna	J&J Janssen	Other _____
	Dose #1 ____ /____ /_____	Dose #2 ____ /____ /_____	Booster ____ /____ /_____

REQUIRED HEALTHCARE PROVIDER VERIFICATION

PHYSICIAN'S NAME (print) _____

PHYSICIAN'S SIGNATURE _____

ADDRESS _____

_____

PHONE _____ DATE _____

PHYSICIAN'S STAMP

MEASUREMENTS AND/OR OTHER FINDINGS

HEIGHT _____ WEIGHT _____ HAIR COLOR _____

EYE COLOR _____ BLOOD TYPE AND RH FACTOR _____

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DECEASED, CAUSE	AGE AT DEATH
Father				
Mother				
Spouse				
Brother(s) and Sister(s)				
Children				

HAS ANY BLOOD RELATIVE (PARENT, BROTHER, SISTER, OTHER) OR SPOUSE EVER HAD:

CHECK EACH ITEM	YES	NO	RELATIONSHIP
Tuberculosis			
Syphilis			
Diabetes			
Cancer			
Kidney Trouble			
Heart Trouble			
Stomach Trouble			
Arthritis			
Asthma/Hay Fever/Hives			
Seizures			
Committed Suicide			
Chemical Dependency			

HAVE YOU EVER HAD OR HAVE YOU NOW (check all that apply):

- ☐ Appendicitis
- ☐ Arthritis or Rheumatism
- ☐ Blood Clots
- ☐ Boils
- ☐ Bone, Joint or Other Deformity
- ☐ Broken Bones
- ☐ Chronic Cough
- ☐ Color Blindness
- ☐ Depression or Excessive Worry
- ☐ Diabetes
- ☐ Dizziness or Fainting Spells
- ☐ Ear, Nose or Throat Trouble
- ☐ Epilepsy or Seizures
- ☐ Eye Trouble
- ☐ Foot Trouble
- ☐ Frequent Indigestion
- ☐ Frequent or Painful Urination
- ☐ Frequent Severe Headaches
- ☐ Frequent Trouble Sleeping
- ☐ Gallbladder Trouble or Gallstones
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Problems
- ☐ Hemorrhoids or Rectal Disease
- ☐ High or Low Blood Pressure
- ☐ Immune Deficiency
- ☐ Infectious Mononucleosis
- ☐ Kidney Stones or Blood in Urine
- ☐ Leg Cramps
- ☐ Loss of Arm, Leg, Finger, or Toe
- ☐ Loss of Memory or Amnesia
- ☐ Measles – German (3-day) (Rubella)
- ☐ Measles (Hard) (Rubeola)
- ☐ Mumps
- ☐ Pain or Pressure in Chest
- ☐ Painful or "Trick" Shoulder
- ☐ Palpitation or Pounding Heart
- ☐ Paralysis (including infantile)
- ☐ Recent Gain or Loss of Weight
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Severe Tooth or Gum Trouble
- ☐ Shortness of Breath
- ☐ Sinusitis
- ☐ Skin Disease
- ☐ Stomach or Intestinal Trouble
- ☐ Sugar or Albumin in Urine
- ☐ Swollen or painful joints
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumor, Growth, Cyst or Cancer
- ☐ Venereal Disease
- ☐ Whooping Cough

☐ Other _____

_____

Is there any other information that might be helpful for us to know? _____

_____

_____

_____

DID YOU EVER OR DO YOU NOW (check all that apply):

- ☐ Wear Glasses/Contact Lenses
- ☐ Wear Hearing Aids
- ☐ Bleed Excessively After Injury or Tooth Extraction
- ☐ Cough Up Blood
- ☐ Wear a Back Brace or Back Support
- ☐ Live with Anyone who Had/Has Tuberculosis
- ☐ Sleepwalk
- ☐ Attempt Suicide

STUDENT'S SIGNATURE _____ DATE _____