Oregon TECH
Integrated Student Health Center

HEALTH HISTORY & TB RISK SCREENING FORM

INTERNATIONAL STUDENTS

Please complete and then e-mail to health@oit.edu or FAX (541-885-1866) prior to traveling to the United States.

NAME:_____
First Last Middle

OIT ID # 918-_____DATE OF BIRTH: _____BIRTH PLACE: _____

GENDER: _____If gender other than birth sex, what was birth sex?_____ Telephone number we can call to reach you_____

Person to be notified in an emergency: _____ **Relationship:** _____**Phone**:_____

Medications: List any medicines you take regularly, including over the counter medications or supplements _____

_____

Allergies: Medications, latex, food, insects etc.: ☐ Yes ☐ No Please list: _____

Are you a tobacco smoker? Yes ☐ No ☐ If so, how often?_____ How much?_____What age did you start? _____

Do you drink alcohol? Yes ☐ No ☐ If so, how often? ☐ 3 or fewer times a month ☐ Once a week or more **How many drinks/week?** ☐ 1 to 2 ☐ 3 to 5 ☐ 6 to 9 ☐ 10+

Personal Medical History:

Please check any of the following as it applies to you:

- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Asthma
- ☐ Back Problem
- ☐ Blood Disorder
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Headaches
- ☐ Head Injury or Concussion
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Muscle/Joint problems
- ☐ Physical Limitations
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Serious Injuries (with date)
- ☐ Sexually Transmitted Infection
- ☐ Skin Disorder
- ☐ Splenectomy
- ☐ Stomach or Intestinal Problem
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Visual Problems
- ☐ Other

Please explain any items you have checked above and date of occurrence:_____

Hospitalizations and Surgeries (with reasons and dates): _____

Mental Health History

Please check any of the following as it applies to you:

- ☐ Act of Self-Harm (cutting, branding, etc)
- ☐ ADD/ADHD
- ☐ Alcohol or Substance abuse or dependence
- ☐ Anger Problems
- ☐ Anti-Social or Conduct Disorder
- ☐ Anxiety Disorder
- ☐ Autism Spectrum
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Learning Disability
- ☐ Obsessive-Compulsive Disorder
- ☐ Panic Disorder
- ☐ PTSD/History of trauma
- ☐ Sleep Disorder
- ☐ Suicidal Ideation
- ☐ Other

Are you now taking or have ever taken medication for any of the above? ☐ Yes ☐ No

Specific medications and dates_____

Do you intend to begin or continue counseling during college? ☐ Yes ☐ No

Have you been hospitalized for a psychiatric disorder? ☐ Yes ☐ No

Have you been treated for alcohol and/or drug addiction? ☐ Yes ☐ No

Family Medical History

Please mark the following if there is a history in your immediate blood relatives, e.g. parents, siblings or grandparents.

	Relationship		Relationship		Relationship
☐ Breast Cancer	_____	☐ Heart Disease	_____	☐ Convulsions/Seizures	_____
☐ Other Cancer	_____	☐ Death before 50	_____	☐ Bleeding Disorders	_____
☐ Stroke/Blood Clots	_____	☐ High Cholesterol	_____	☐ Mental Health Condition	_____
☐ High Blood Pressure	_____	☐ Diabetes	_____	☐ Alcohol or Drug Abuse	_____

***All information disclosed on this form will be kept confidential and will be shared with appropriate college personnel on a need-to know basis only.**

Office Use
TB complete _____
MMR complete _____

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Required Vaccinations for Admission:

Per Oregon Administrative Rule 333-050-0130: All entering university students born on or after January 1, 1957 will have **two doses of MMR** (measles, mumps, rubella) which are at least 24 days apart and the first dose was up to 4 days prior to or after the student's first birthday. **Documentation is required for these immunizations.** Indicate which of the following documentation you have attached to this form (copies are acceptable):

- ☐ Doctor's office or medical clinic records
- ☐ Public Health Department records
- ☐ Your high school or previous college immunization records
- ☐ Personal immunization card signed by clinic staff
- ☐ Serological Confirmation of Immunity: Lab test (titer) for Measles, Mumps, and Rubella may be substituted as proof of immunity in lieu of vaccinations. Copies of lab work must be attached.

You must have at least 1 documented MMR vaccine on file before being allowed to register.

Required Tuberculosis Exposure Information:

1. Have you ever had close contact with persons known or suspected to have active TB disease? □ Yes □ No
2. Were you **Born** in one of the countries listed below that have a high incidence of active TB disease*?If yes, check "**B**" below next to your birth country. □ Yes □ No
3. Have you had frequent/prolonged **Visits** to 1 or more of the countries listed below? Check "**V**" for each □ Yes □ No

B	V		B	V		B	V	
		Angola			Guinea-Bissau			Philippines
		Azerbaijan			India			Republic of Moldova
		Bangladesh			Indonesia			Russian Federation
		Belarus			Kazakhstan			Sierra Leone
		Botswana			Kenya			Somalia
		Brazil			Kyrgyzstan			South Africa
		Cambodia			Lesotho			Swaziland
		Cameroon			Liberia			Tajikistan
		Central African Republic			Malawi			Thailand
		Chad			Mozambique			Uganda
		China			Myanmar			Ukraine
		Congo			Namibia			United Republic of Tanzania
		Democratic People's Republic of Korea			Nigeria			Uzbekistan
		Democratic Republic of Congo			Pakistan			Viet Nam
		Ethiopia			Papua New Guinea			Zambia
		Ghana			Peru			Zimbabwe

** Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2016-2020 Countries with incidence rates of ≥20 cases per 100,000 population. For future updates, refer to* www.who.int

4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? □ Yes □ No
5. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB? □ Yes □ No
6. Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or someone who abused drugs and/or alcohol? □ Yes □ No

If the answer to all of the above questions is NO, no further testing or further action is required.
If the answer is YES to any of the above questions, Oregon Tech requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent quarter. Please see our website for details.

7. If you are providing documentation of a TB skin test, was it performed after exposure to any of the above identified risks in Questions 1 through 6? □ N/A □ Yes □ No

3201 Campus Dr., Klamath Falls, Oregon 97601; Phone: 541-885-1800 Fax: 541-885-1866; health@oit.edu

Office Use
TB complete _____
MMR complete ____