WESTERN OREGON UNIVERSITY
STUDENT HEALTH and COUNSELING CENTER (SHCC)
HEALTH HISTORY

Please return completed form to the Student Health and Counseling Center at Western Oregon University
345 North Monmouth Avenue, Monmouth OR 97361 Fax: 503 838-8801 Telephone: 503 838-8313

_____ _____
LAST NAME FIRST MIDDLE NAME OF PARENT, GUARDIAN or SPOUSE

_____ _____
CAMPUS / LOCAL ADDRESS, IF KNOWN HOME ADDRESS of PARENT, GUARDIAN or SPOUSE

_____ _____
CITY STATE ZIP CITY STATE ZIP

Sex Assigned at Birth: Male ____ Female____Gender:_____

Pronouns: She/Her/Hers_____He/Him/His _____They/Them/Theirs _____

Ze/Hir/Hirs _____Other _____

Cell Number _____

Person to be notified in case of emergency:
_____
NAME RELATIONSHIP TO STUDENT

Student V Number_____

_____
TELEPHONE NUMBER

Date of Birth_____ Age_____

State or Country of Birth_____ Term entering WOU_____

PERSONAL AND FAMILY HISTORY (check YES answers only)

	You	Family(parents, siblings)	Please explain
Alcoholism / Drug Abuse			
Allergies / Environmental			
Anemia or Blood Disease			
Asthma			
Cancer			
Diabetes			
Gastrointestinal Disorder			
Head Injury			
Hearing Loss			
Heart Disease			
Hepatitis			
High Blood Pressure			
Kidney Disease			
Mental Illness (depression, anxiety, eating disorders)			
Muscle / Joint Disease			
Rheumatoid Arthritis			
Seizure Disorder			
Serious Illness/Hospitalization			
Thyroid Disease			
Tuberculosis			

Allergies to medication(s)_____
Medical Problems currently under treatment_____
Prior surgeries (types and dates)_____
Chronic illness/disabilities _____
(for accommodations contact Disability Services at 503 838-8250)
Drugs/Medicines you use regularly (include contraceptives, herbal medicine, inhalers, supplements)_____

_____ _____
STUDENT SIGNATURE DATE

LAST NAME FIRST MIDDLE STUDENT V NUMBER

Safety History:

	Yes	No
Has a partner or friend ever hit, kicked, or otherwise hurt or threatened you?		
Do you or your roommates have any weapons at your school residence? If yes, are they kept locked?		
Have you ever experienced any unwanted sexual encounters you want to discuss?		
Do you have any concerns about violence at home or school?		

Mental Health History

	Yes	No
Have you ever been seen by a counselor, psychiatrist, or mental health practitioner? If yes, when?		
Have you ever taken medication for mental health problems? If yes, when?		
Have you ever received medical care or been hospitalized for a mental health problem or an eating disorder? If yes, when?		
Have you ever received medical care or been hospitalized for substance abuse? If yes, when?		
Have you ever thought things would be better if you were dead? If yes, when?		
Have you had thoughts of harming or killing yourself? If yes, when?		

Social History:

	Yes	No
Do you drink alcohol? If yes, # drinks per week		
Do you currently use tobacco? Cigs, E-Cigs,Hookah, Chew		
Do you smoke marijuana? If yes, how often?		
Have you used other recreational drugs besides marijuana in the past 6 months? If yes, what?		
Have you ever used prescription medication other than what has been prescribed for you? If yes, what?		
Have you passed out or had memory blanks as a result of drinking?		
Are you in recovery from alcohol or drug addiction?		
Are you interested in support to lead a sober lifestyle?		

LAST NAME FIRST MIDDLE _____ STUDENT V NUMBER

OFFICE USE ONLY
CLEARED
MMR Date _____
Initials_____

IMMUNIZATION HISTORY

YOU WILL NOT BE ALLOWED TO COMPLETE YOUR REGISTRATION OR ATTEND CLASSES IF DOCUMENTATION IS NOT RECEIVED.

REQUIRED IMMUNIZATIONS: Measles (Rubeola/Hard Measles – 2 doses)

See our webpage for a list of recommended vaccines www.wou.edu/student/health/

Each student who was born on or after January 1, 1957 must have two doses of measles vaccine. Adequate proof includes:

1. Two doses (documented by month, day and year of each dose) no earlier than 4 days before the first birthday, with a minimum of 24 days between the doses; or
2. For students born prior to 1984, no available documentation for the month, day and year of the first dose but documentation of the month, day and year of the second dose on or after December, 1989. International students need documentation for both dates.
3. Documentation of physician diagnosed measles (see exemption box below)
4. Blood test showing evidence of immunity (see exemption box below)

Accepted documentation is:

- Doctor's office or medical clinic records. International Students, please have records in English.
- Public Health Department records
- Personal immunization card (signed by clinic staff)
- Your high school or previous college immunization records
- Print out from statewide immunization information system (ALERT IIS)

TO PROVIDE DOCUMENTATION OF YOUR MEASLES IMMUNIZATIONS, STAPLE A COPY OF YOUR IMMUNIZATION RECORDS TO THIS FORM.

AGE, MEDICAL OR NON-MEDICAL EXEMPTION FOR TWO-DOSE MEASLES VACCINE

_____ **AGE EXEMPTION**

I was born before January 1, 1957 and am therefore considered immune
Date of birth (month/day/year)_____

_____ _____
STUDENT SIGNATURE DATE

_____ **MEDICAL EXEMPTION**

I certify the above-named student should be exempted from the requirements for the measles vaccine based on:

A History of measles (month/year) _____
B Immune titer shows immunity to measles (month/year)_____
C The following medical reason _____
Constitutes a medical contraindication in accordance with the advisory committee on immunization practices of the U.S. Public Health Service for measles vaccine.

_____ _____
SIGNATURE OF HEALTH CARE PRACTITIONER DATE

_____ _____
PRINTED NAME & TITLE OF HEALTH CARE PRACTITIONER DATE

_____ **NON-MEDICAL EXEMPTION**

You are required by Oregon State Law to receive education about the benefits and risks of vaccination prior to claiming the non-medical exemption. You have two options:

1. Talk to a healthcare provider and have them sign the Vaccine Education Certificate below. This form will need to be submitted to the SHCC before the exemption will be accepted.

VACCINE EDUCATION CERTIFICATE

I have reviewed the information about the benefits and risks of vaccination with:
Student's Name (printed):_____
Pursuant to the rules adopted under ORS 433.273, for attendance to an Oregon college or university, the vaccine-preventable disease measles.
Health Care Practitioner's Signature:_____Date:_____
__MD __DO __ND __NP __PA __RN working under the direction of an MD, DO, ND or NP
Clinic Name:_____
Optional: ORS 433.267 states that this document may include the reason for declining the immunization.
Immunization is being declined because of: __Religious Belief __Philosophical belief __Other

2. View an on-line vaccine education module located at ***www.healthoregon.org/vaccineexemption***
You must print the certificate of completion and submit it to the SHCC before the exemption will be accepted.