



WESTERN
ILLINOIS
UNIVERSITY

Beu Health Center

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Macomb, IL 61455-1390

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Health History Form

It is important that you complete this form with detailed, factual information in order for you to be provided with the best possible medical care while you are a student at Western Illinois University.

NAME			
LAST:	FIRST:	MI:	WIU ID #:
DATE OF BIRTH			
(MM-DD-YY):	AGE:	MALE _____ FEMALE _____	E-MAIL:
WIU ADDRESS:		PREFERRED CONTACT PHONE #:	
PERMANENT (HOME)			
ADDRESS:	CITY:	STATE:	ZIP:
PARENT/GUARDIAN/SPOUSE			PARENT/GUARDIAN
NAME:			AREA CODE/PHONE #:
PARENT/GUARDIAN			
ADDRESS:	CITY:	STATE:	ZIP:
CONTACT IN CASE OF EMERGENCY			
NAME:	PHONE:	RELATIONSHIP:	
ALLERGY HISTORY		Date of first admission to Western Illinois University (month/year): _____	
Are you currently taking any prescription medications, non-prescription medications, herbal products, or dietary supplements? NO ___ YES ___		FOR OFFICE USE ONLY:	
If YES, please list and explain:		DATE RECEIVED: _____	
Do you have any allergies or sensitivities to medication? NO ___ YES ___		INITIALS: _____	
1) _____ 2) _____			
IF YES, PLEASE INDICATE TYPE OF REACTION (HIVES/RASH/ETC.):			
CONFIDENTIALITY NOTICE		<u>PLEASE SUBMIT ALL INFORMATION TO</u>	
The information contained on this health form is legally privileged and confidential and is intended only for the use of BEU HEALTH CENTER. The copying or distribution of this document is prohibited without express permission of individual named above.		<u>INCLUDE IMMUNIZATIONS BY AUGUST 1</u>	
		<u>FOR FALL ADMISSION AND JANUARY 1 FOR</u>	
		<u>SPRING ADMISSION.</u>	

YOUR MEDICAL HISTORY

Please check conditions you now have or have had in the past.

Allergy symptoms	Hay Fever	Mononucleosis	Surgery (specify):
Arthritis	Headaches	Organ Transplant	
Asthma	Hearing Problems	Pneumonia	
Back Problems/Injury	Hernia	Rheumatic Fever	
Bladder Problems	Heart Murmur (explain medication needs if indicated)	Seizure Disorder	Fractures (specify):
Bowel problems		Sinus Problems	
Bronchitis	Heart Problems	Skin Problems	
Chicken Pox	Hepatitis	Substance Abuse	
Concussion	Hives	Thyroid Disease	
Depression	Hypertension	Tonsillitis	
Diabetes	Hypotension	Tuberculosis	
Ear, Nose, Throat Problems	Kidney Problems	Ulcers	
Eating Disorder	Meningitis	Vertigo or Dizziness	
Eczema	Menstrual Problems	Visual Disturbances	
Epilepsy	Migraine Headaches	Whooping Cough	

Comments related to any of those marked above:

A. Do you have an illness or condition not previously listed for which you are now being treated?
If YES, please specify:

B. Please list any treatments and dates of treatment received at a hospital (emergency room, etc.):

C. Have you had symptoms and/or treatment for emotional or psychological problems?
Describe and list current medications:

Please attach any additional information that your family health care provider would like to share concerning treatments received.

AGREEMENT AND CONSENT

The undersigned may voluntarily seek medical and/or surgical treatment or diagnosis and request that reports of same be exchanged between Beu Health Center, McDonough District Hospital, and other health care providers as deemed necessary by the physicians responsible for care of the undersigned.

This agreement is valid for the period of time during which the undersigned is eligible for care by Beu Health Center, and this consent for release of information may be revoked in writing at any time. It is understood that in accord with the Illinois Mental Health and Development Disabilities Confidentiality Act, and the Confidentiality of Alcohol and Drug Abuse Patient Records statutes, 42 CFR 2.54 (1891), that information will not be further disclosed by the above agencies without permission of the undersigned.

Date: _____

Signature of student: _____

Signature of parent/guardian: _____

Must be signed by parent/guardian if the student is under 18 years of age by the first day of classes at WIU.