Western Illinois University

Beu Health Center

1 University Circle
Macomb, IL 61455-1390

Phone: 309/298-1888
Fax: 309/298-1122

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 NAME:			PARENT/GUARDIAN AREA CODE/PHONE #:
PARENT/GUARDIAN ADDRESS:	CITY:	STATE:	ZIP:
CONTACT IN CASE OF EMERGENCY NAME:	PHONE:	RELATIONSHIP:	

ALLERGY HISTORY

Are you currently taking any prescription medications, non-prescription medications, herbal products, or dietary supplements? NO____ YES____

If YES, please list and explain:

Do you have any allergies or sensitivities to medication? NO____ YES____

1)____ 2)____

IF YES, PLEASE INDICATE TYPE OF REACTION (HIVES/RASH/ETC.):

Date of first admission to Western Illinois University (month/year):______________________________

FOR OFFICE USE ONLY:

DATE RECEIVED: ________________________

INITIALS: ________________________

CONFIDENTIALITY NOTICE

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.

PLEASE SUBMIT ALL INFORMATION TO INCLUDE IMMUNIZATIONS BY AUGUST 1 FOR FALL ADMISSION AND JANUARY 1 FOR SPRING ADMISSION.

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	Other (specify):
	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.