Medical History Form

Southern Illinois University Edwardsville Health Service

_____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____
ID Number SSN Date of Birth (MO/DAY/YR)

Emergency Contact: Parent, Guardian or Spouse _____

(____)_____ _____ _____ _____
Telephone Address City Zip Code

For informational purposes only:

Are you covered by Hospitalization / Medical insurance? Yes No

Personal History:	Yes	No		Yes	No		Yes	No
Acne / Skin disorders			Hepatitis			Recent weight changes		
Ear problems			Hemorrhoids			Eating disorder		
Hearing loss			Hernia			High blood cholesterol		
Eye trouble (except glasses)			Frequent or severe headaches			Low blood sugar		
Frequent colds			Head injury with unconsciousness			Diabetes		
Sinus trouble			Dizziness/ fainting spells			Mononucleosis		
Thyroid problems			Kidney / urinary tract problems			Chicken pox		
Heart problems/murmur			Gynecological problems			Cancer		
High / low blood pressure			Prostate troubles			Malaria		
Bleeding / blood disorders			Sexually transmitted diseases			Counseling or Mental Health treatment		
Respiratory / breathing problems			Ever been sexually assaulted?			Any medical disability		
Tuberculosis			Arthritis			Do you use recreational drugs?		
Gastrointestinal problems			Back trouble			Do you use alcohol?		
Gallbladder problems			Fractures			Do you use tobacco?		

Please explain the answers marked YES above _____

_____

_____

List any medications taken on a regular basis (including birth control pills) _____

_____

ALLERGIES:

Drugs _____

_____

Other _____

_____

Family history:	Yes	No
Tuberculosis		
Heart problems		
Stroke		
Cancer		
Diabetes		

I hereby declare that all information on this form is complete and true to the best of my knowledge.
I acknowledge that the contents of my medical record may be used by the SIUE Health Service regarding payment, treatment, and operational activities. Full "Notice of Privacy Practices/Patient's Rights and Responsibilities" available upon request.
I CONSENT AND AUTHORIZE THE SIUE HEALTH SERVICE TO PROVIDE CARE TO ME FOR WHATEVER EXTENT IS DEEMED ADVISABLE WITHIN THE BEST JUDGEMENT OF THE HEALTH CARE PROVIDER.

_____ _____
Signature Date