SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
COUNSELING AND HEALTH SERVICES

MEDICAL HISTORY & CONSENT FORM

_____ _____ _____
PRINT Last Name First Name Middle Initial

_____ _____ _____
SIUE 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 Health Care Insurance? _____yes _____no
Insurance Company Name: _____

Please answer the following:

Do you have any long-term medical/psychological condition(s)? Please list _____

_____

Have you had any surgeries in the past? Please list _____

_____

List any medications (include over-the-counter meds, herbal remedies) that you take on a regular basis (including birth control measures) _____

_____

Do you use tobacco? _____yes _____no How often? _____
Do you use alcohol? _____yes _____no How often? _____
Do you use recreational drugs? _____yes _____no Which ones? _____

Have you traveled overseas in the last year? _____yes _____no Where? _____

I AM ALLERGIC TO: _____

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 Counseling and Health Services 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 COUNSELING AND HEALTH SERVICES TO PROVIDE CARE TO ME FOR WHATEVER EXTENT IS DEEMED ADVISABLE WITHIN THE BEST JUDGEMENT OF THE HEALTH CARE PROVIDER.

_____ _____ _____
Signature Today's Date Call me at this telephone #