**STUDENT HEALTH CENTER**

**HEALTH HISTORY FORM**

Please complete *both pages* in ink, and sign the Permission to Treat. Minors must have the Permission to Treat signed by parent/guardian. Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your written authorization, except as required by law, subpoena or court order.

Name Sex (Check one.)

Male

Female U #

Place of Birth (City, State, Country) Age Date of Birth

Permanent Address (Street, City, State, Zip)

Local Address (Street, City, State, Zip)

Cell Phone Home Phone Work Phone

Email Classification

Student

Faculty/Staff

Visitor

**Emergency Notification** Name Relationship to you

Cell Phone Home Phone Work Phone

Check here if you or any blood relative has had any of the following:

Alcohol or Drug Abuse

Anemia or Blood Disease

Cancer

Epilepsy

Heart Disease

Infectious Disease

Mental or Emotional Disorder

Rheumatoid Arthritis

Suicide or Attempt

Other

Prior surgeries and dates

Prior major injuries and dates

Prior infectious diseases and dates (includes childhood diseases, Mono, TB, HIV, Hepatitis and Sexually Transmitted Infections)

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Ulcer

Stroke

Physical Disability

Kidney Disease

High Blood Pressure

Hearing Loss

Diabetes

Asthma

Allergies or Hay Fever

List **all medications** you take routinely (include prescriptions, over-the-counter medicines, diet pills, inhalers, allergy shots, vitamins, supplements and birth control pills, shots or implants)

List **all allergies** you have including drug and non-drug allergies Allergies (such as latex, nuts, bites or stings, etc.)

Type of Reaction (rash, hives, swelling, etc.)

Do you use tobacco?

Yes

No

What form? Usage per day?

Former smokers: How many cigarettes/day? For how long? How long ago did you quit?

Do you use alcohol (includes beer)?

Yes

No

How often? Usage per occasion?

Do you use drugs?

Yes

No

What form? How often?

Have you ever been treated for alcohol and/or drug abuse?

**Permission to Treat**

Permission is hereby granted to the Student Health Services healthcare providers and staff to proceed with any needed emergency and/or non-emergency treatment, examinations, immunizations and medical tests should medical or surgical attention be necessary while the student is enrolled at the University of Memphis. I understand that under certain circumstances, transportation to an area hospital for diagnosis, treatment and possible hospital admission may be necessary. I also understand that the expenses incurred for medical care beyond that which is provided within Student Health Services are my responsibility.

In addition, if the student is a Minor, in the event of serious illness or significant accidental injury, an attempt will be made by Student Health Services staff to contact a parent or legal guardian in the most expeditious manner possible. If said staff is unable to communicate with a parent or legal guardian, medically necessary treatment which is in the best interests of the Minor as determined by medical professionals may be given. I (parent or legal guardian) further give Student Health Services staff permission to contact my son’s/daughter’s primary healthcare provider regarding past medical and medication history, if necessary.

Signature of Student

Signature of Parent/Guardian

*(If student is under 18)*

Date

Date

**Emergency Contact Information**

Name

**Parent/Guardian Contact Information**

Name

Address

Address

City, State, Zip

City, State, Zip

Home Phone

Home Phone

Work Phone

Work Phone

Cell Phone

Cell Phone

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