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.):

+H[L VM ÄYZ[HKTPZZPVU [V
Western Illinois University (month/year):_____

FOR OFFICE USE ONLY:

DATE RECEIVED: _____

INITIALS: _____

CONFIDENTIALITY NOTICE

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