THE UNIVERSITY OF MEMPHIS®
Student Health and Counseling Services

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:

	You	Relative/Relationship	Remarks
Alcohol or Drug Abuse	☐	☐	
Allergies or Hay Fever	☐	☐	
Anemia or Blood Disease	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Epilepsy	☐	☐	
Hearing Loss	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Infectious Disease	☐	☐	
Kidney Disease	☐	☐	
Mental or Emotional Disorder	☐	☐	
Physical Disability	☐	☐	
Rheumatoid Arthritis	☐	☐	
Stroke	☐	☐	
Suicide or Attempt	☐	☐	
Ulcer	☐	☐	
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) _____

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 _____

Address _____

City, State, Zip _____

Home Phone_____

Work Phone_____

Cell Phone_____

Parent/Guardian Contact Information

Name _____

Address _____

City, State, Zip _____

Home Phone_____

Work Phone_____

Cell Phone_____