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) __________

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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) ____________________

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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 ____________________

Date ____________________

Signature of Parent/Guardian ____________________
(If student is under 18)

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 ____________________

The University of Memphis is an Equal Opportunity/Affirmative Action University.