

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			PARENT/GUARDIAN
NAME:			AREA CODE/PHONE #:
PARENT/GUARDIAN			
ADDRESS:	CITY:	STATE:	ZIP:
CONTACT IN CASE OF EMERGENCY			
NAME:	PHONE:	RELATIONSHIP:	
ALLERGY HISTORY		+ H [L V M Ä Y Z [H K T P Z Z P V U [V Western Illinois University (month/year): _____	
Are you currently taking any prescription medications, non-prescription medications, herbal products, or dietary supplements? NO ___ YES ___		FOR OFFICE USE ONLY:	
If YES, please list and explain:		DATE RECEIVED: _____	
Do you have any allergies or sensitivities to medication? NO ___ YES ___		INITIALS: _____	
1) _____ 2) _____			
IF YES, PLEASE INDICATE TYPE OF REACTION (HIVES/RASH/ETC.):			
CONFIDENTIALITY NOTICE			
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