

PERSONAL MEDICAL HISTORY

Are you being treated for any medical condition? Yes___ No___
Specify:_____

Have you ever had surgery? Yes___ No___
Specify:_____

Do you have or have ever been told that you have a heart condition? Yes___ No___
Specify:_____

Have you ever had a head injury with a loss of consciousness? Yes___ No___
Date:_____ Was a CAT scan done?_____

Are you **ALLERGIC** to **ANYTHING** - including prescription medications, over the counter medications, foods, insects, inhalants? Please specify allergy or reaction.

Allergic to:_____

Reaction: _____

CONFIDENTIALITY:

As a consumer of our services, confidentiality is your right, except where limited by the ethics of our practice and the law. Should you choose to have information released about you to a third party, this will be done only with your consent. Please sign to verify acknowledgement of this information.

Student Signature_____ Date_____

AUTHORIZATION FOR TREATMENT:

I hereby authorize the Wilkes University Health Services to treat any illness or injury as deemed necessary by the staff. In the case of a serious medical emergency, please be advised that the student will be transported to the nearest health care facility. During a medical emergency, every effort will be made to notify the contact person listed on the health history form. All bills incurred will be the responsibility of the student.

Student Signature_____ Date_____

If involved in **Intercollegiate Sports**, can this form be used as part of your physical exam? Yes___No___

Student Signature_____ Date_____