DILLARD UNIVERSITY

STUDENT HEALTH SERVICES

Medical History Form

Last Name: _____ **First:** _____ **MI:** _____ **Dillard Student ID#** _____
Primary email address: _____@_____. _____
Permanent Address: City _____ **State:** _____ **Zip code:** _____
Birthdate: _____/_____/_____ **Citizenship: USA** _____ **Other (Specify)** _____

MANDATORY
Emergency contact: Last Name: _____**First:** _____ **Relationship:** _____
Address: City _____ **State:** _____ **Zip Code:** _____
Home: (_____) _____ **Work:** (_____) _____ **Mobile:** (_____) _____

Health Insurance Company: _____ **Policy Number:** _____

(Please attached a copy of the front and back of the insurance card)

List all allergies and reactions to the following if applicable:

Medications: _____

Foods: _____

Environmental: _____

List current medications and dosage of medication: (Prescription and over-the-counter).

_____ _____ _____

_____ _____ _____

History of Surgery: _____Y _____N **(If yes, name of surgery and year):**_____

_____

Have you ever had any of the following: (Check all that Apply)

☐ Alcohol Abuse	☐ Drug Abuse	☐ Depression	☐ Tobacco Use
☐ Anemia	☐ Arthritis	☐ Asthma	☐ Cancer
☐ Chronic Cough	☐ Back problems	☐ Colitis	☐ Diabetes
☐ Seizures	☐ Eating Disorders	☐ Hepatitis	☐ Heart Disease
☐ Chronic headaches/ Migraine	☐ Head Injury	☐ Hernia	☐ Hemophilia
☐ Intestinal/ stomach disorder	☐ Heart Murmur	☐ Kidney Disease	☐ Mono
☐ Pneumonia	☐ COVID-19	☐ Polio	☐ Mumps
☐ Menstrual problems	☐ Orthopedic problems	☐ Rheumatic fever	☐ Stroke
☐ Sleep disorders	☐ Splenectomy	☐ Chronic sinus infections	☐ Tuberculosis
☐ Chronic urinary infections	☐ Thyroid disease	☐ (+) Tb Skin Test	☐ Chicken Pox

If you have checked any of the above boxes, please give a brief history _____

_____

I certify that the Medical history provided is accurate and complete to the best of my knowledge.

_____ _____
Student Signature **Date**

_____ _____
Parent or Guardian Signature **Date**