

Northern Illinois University

Health Services

A Division of Student Affairs

DeKalb, Illinois 60115

(815)-753-1311, Fax (815)-753-9599

ALLERGIES:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
attach allergy sticker	

HEALTH HISTORY FORM Please print all information

Name (last) _____ (first) _____ (m.i.) _____			
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth - -	Age	NIU ID
Permanent address (street) _____ (city/state) _____ (zip) _____			Phone ()
Emergency contact (name) _____		(relationship) _____	(Phone) ()

ALLERGIES

Please check (✓) any of the following ALLERGIES that apply to YOU and explain reaction in area provided

Aspirin	Food	Penicillin	Sulfa
Codeine	Latex	Pollen	Other

PERSONAL HISTORY

Please check (✓) any of the following conditions that apply to YOU and explain in the area below

Alcohol/Substance Abuse	Cancer	Heart Disease	Rheumatic Fever
Anemia	Chickenpox	Heart Murmur	Sexually Transmitted Disease
Arthritis	Crohn's Disease	Hepatitis	Significant Injury
Asthma	Cystic Fibrosis	High Blood Pressure	Smoking
Back Problems	Diabetes	HIV Positivity	Thyroid Condition
Birth Defect	Ear Problems	Kidney Problems	Tuberculosis
Bladder Infections	Eating Disorder	Meningitis (Type)	Ulcerative Colitis
Bleeding Disorders	Eczema	Mental Illness	Ulcers (stomach)
Breast Problems	Epilepsy or Seizures	Migraine Headaches	
Bronchitis	Fast/Irregular Heart Beat	Mitral Valve Prolapse	
Are you currently being treated for an illness or condition?			
Have you been hospitalized for medical treatment or surgery?			
Are you currently taking any over-the-counter medication and/or prescription medication?			
Have you had severe symptoms and/or treatment for insomnia, anxiety, depression, persistent suicidal thoughts, mental/physical/substance abuse, or any other mental or emotional disorder?			
During your lifetime have you traveled or lived outside of the US for over 30 days? If Yes, when and where?			

FAMILY HISTORY

Please check (✓) any of the following conditions that apply to your FAMILY.

Alcoholism	Cancer	Hypertension	Sudden Death before age 50
Allergies	Diabetes	Mental Illness	Other
Asthma	Heart Disease	Migraine Headaches	Other

PLEASE EXPLAIN ANY ITEMS CHECKED IN PERSONAL OR FAMILY HISTORY:

I certify that the above history is complete and correct to the best of my knowledge. I hereby give permission for the medical staff of Northern Illinois University, Health Services to perform such diagnostic, therapeutic and operative procedures as they deem necessary.

Signature of Patient

Date