Department of Student Wellness
Health Services
1200 Commercial-Box 4008, Emporia, KS 66801
620-341-5223, shc@emporia.edu, Fax: 620-341-5045

Health History Form

Name____ Soc. Security No.________________
(Please Print) Last First Middle

Date of Birth____________________ Height ___________ Weight _________ Gender______________

Local Address____
Street City

____
State Zip Local Telephone

Parent/Legal Guardian/Spouse____

Permanent Address_______________________________________ Telephone____________________

Family Physician____ Telephone____________________

Address____

Are you allergic to any medication(s)? (Please list)____

____

Do you take any medication(s) on a routine basis? (Please list)_________________________________

____

Do you have any chronic conditions such as asthma, hypertension, diabetes? (Please list)

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Please list any serious illnesses, injuries, or surgeries you have had.____________________________

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Please list serious illnesses of close relatives (cancer, diabetes, heart disease, TB, etc.) ___________

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