Washington University in St.Louis

Student Health Service

Email: StudentHealthService@wusm.wustl.edu
(314) 362-3523 Fax (314) 362-0058
660 S. Euclid • Box 8030 • St. Louis, MO 63110

Office use only

This record is required, is kept in confidence, and has no bearing on your academic status.
Please fill in the personal history completely and legibly.
This will become part of your confidential health record while at
Washington University and will be kept in your personal health folder.

Please Print

Last Name: _____ First Name: _____ Mi: _____

Date of Birth: _____ Place of Birth: _____ Gender At Birth: _____

WUSTL E-mail: _____

Please supply your St. Louis Address ONLY

Street: _____ City: _____ State: _____ Zip: _____

Phone Number _____ Campus Telephone: _____

Marital Status

Name of Previous College: _____

Years of attendance: _____

Parent, Guardian, Spouse: Emergency Contact

Name: _____ Relation: _____

Address: Street: _____ City: _____ State Zip _____

Phone Number

Are you covered by private insurance? ☐ **Yes** ☐ **No**

If yes, name of company: _____

Policy/Group Number _____

Expiration date: _____

Student Health is always secondary with private insurance. http://wusmhealth.wustl.edu

Program in Which You Will Enroll

☐ Medical ☐ Medical Scientist Training Program
☐ Occupational Therapy ☐ Physical Therapy
☐ Graduate, Biomedical Science
☐ PACS • Program length: _____
☐ Other: _____ ☐ Spouse/Dependent

Date starting school

- Have you been hospitalized within 10 years: ☐ Yes ☐ No

If yes, indicate when, where, and why in the space below.

- Have you had surgery within 5 years? ☐ Yes ☐ No

If yes, indicate when, where, and why in the space below.

- Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, indicate why in the space below.

- Are you now being treated for any mental and/or physical illness? ☐ Yes ☐ No

If yes, indicate the condition and forms of therapy in the space below.

- Have you ever been diagnosed with Hepatitis B? ☐ Yes ☐ No
- Have you ever been diagnosed with Hepatitis C? ☐ Yes ☐ No
- Have you ever been diagnosed with HIV? ☐ Yes ☐ No
- Tobacco use? ☐ Yes ☐ No If yes, please describe use _____
- Alcohol use? ☐ Yes ☐ No If yes, please describe use _____

Comments:

_____

_____

_____

_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things.	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

Are you allergic to penicillin? ☐ Yes ☐ No

to sulfa? ☐ Yes ☐ No

to other drugs? ☐ Yes ☐ No

if yes, to what drug(s):_____

Please list any medication you are currently taking: (**Please ensure you arrive with 1 -2 month supply of medication.)**

_____

_____

_____

_____

If you have a medical problem that may require continued medical supervision, please authorize your physician to forward relevant information to:

Student Health Service
Washington University Medical School
660 S. Euclid Ave, Box 8030
St. Louis, MO 63110
Phone: (314) 362-3523
Fax: (314) 362-0058

As the person signing this consent, I understand that I am giving Student Health Service my permission to communicate protected health information as defined under the HIPAA or FERPA. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Student Health Service, or will it affect my eligibility for benefits.

I hereby give WUSM Student Health Service my permission to transmit communications to me via E-mail, and/or call me at the listed telephone number leaving a voicemail when unavailable. We want to make sure you know that unencrypted email is not a secure means of communication and we will encrypt our email communications to you unless you tell that you prefer us to use unencrypted email.

Voicemail may be used: □ Yes □ No

Telephone number that may be used:_____

Unencrypted E-mail may be used: □ Yes □ No
Authorized E-mail: _____

_____ _____
Student's Signature Date