



UNIVERSITY OF NORTH TEXAS

# Student Health *and* Wellness Center

PO Box 305160  
Denton, Texas 76203-5160  
(940) 565-2333  
Fax: (940) 565-4559

List Allergies to Medications

\_\_\_\_\_

\_\_\_\_\_

ID# \_\_\_\_\_  
SS# \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI

Race \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

Parents/Legal Guardian/Spouse \_\_\_\_\_ Tele (\_\_\_\_) \_\_\_\_\_

Address/City \_\_\_\_\_

Mother's maiden name \_\_\_\_\_ City/State of Patient's Birth \_\_\_\_\_

Personal usage of: Alcohol \_\_\_\_\_ Drug \_\_\_\_\_ Tobacco \_\_\_\_\_

Contraceptive Used \_\_\_\_\_

Routine Medication \_\_\_\_\_

Do you have a chronic condition? \_\_\_\_\_ If so, who is your treating provider? \_\_\_\_\_

Have you been treated for the following? (√ Yes Answers Only)

\_\_\_\_\_ Abnormal Bleeding Tendency \_\_\_\_\_ Drug Use \_\_\_\_\_ Recurrent Headaches

\_\_\_\_\_ Alcohol Use \_\_\_\_\_ Epilepsy/Seizure \_\_\_\_\_ Rheumatic Fever

\_\_\_\_\_ Anemia \_\_\_\_\_ Emotional/Mental Illness \_\_\_\_\_ Surgery

\_\_\_\_\_ Anxiety/Worry \_\_\_\_\_ Food/Pollen Allergies \_\_\_\_\_ Severe Visual Problem

\_\_\_\_\_ Arthritis \_\_\_\_\_ Frequent Indigestion \_\_\_\_\_ Stomach Ulcer

\_\_\_\_\_ Asthma \_\_\_\_\_ Gall Bladder \_\_\_\_\_ Tuberculosis

\_\_\_\_\_ Cancer \_\_\_\_\_ GERD (Acid Reflux) \_\_\_\_\_ Typhoid Fever

\_\_\_\_\_ Chicken Pox \_\_\_\_\_ Heart Disease \_\_\_\_\_ Unusual Childhood Disease

\_\_\_\_\_ Chronic Back Problems \_\_\_\_\_ Hepatitis \_\_\_\_\_ Urinary Tract Infection

\_\_\_\_\_ Chronic Cough \_\_\_\_\_ Hernia \_\_\_\_\_ Other

\_\_\_\_\_ Chronic Skin Problems \_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Colitis or Colon Problems \_\_\_\_\_ HIV

\_\_\_\_\_ Congenital Heart Problems \_\_\_\_\_ Inf. Mononucleosis

\_\_\_\_\_ Convulsions/Seizures \_\_\_\_\_ Kidney Disease

\_\_\_\_\_ Depression \_\_\_\_\_ Malaria

\_\_\_\_\_ Diabetes \_\_\_\_\_ Measles

\_\_\_\_\_ Diminishing Hearing \_\_\_\_\_ Mumps

\_\_\_\_\_ Dizziness/Fainting Spells \_\_\_\_\_ Pneumonia

### Family History

\_\_\_\_\_ Abnormal Bleeding Tendency

\_\_\_\_\_ Cancer

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Epilepsy/Seizure

\_\_\_\_\_ Heart Disease

\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Tuberculosis

\_\_\_\_\_ Other

Have you been hospitalized? (explain) \_\_\_\_\_ Date \_\_\_\_\_

### IMMUNIZATIONS HISTORY:

DT \_\_\_\_\_ HepB \_\_\_\_\_ MMR \_\_\_\_\_ Polio \_\_\_\_\_ Meningitis \_\_\_\_\_  
Date Date Date Date Date

I hereby certify the above history is complete and true.

Signature of Patient / Parent / or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Provider Reviewed \_\_\_\_\_ Date \_\_\_\_\_

See Other Side

**Authorization for Treatment (if patient is over 18 years of age)**

I do hereby consent, authorize, and request Student Health and Wellness Center personnel, and/or physician and/or mental health representative and/or other medical representative to whom referral is made, to conduct treatment which they may deem advisable in the event that I should require medical care while a student at the University of North Texas. I also agree to pay all charges incurred at the time of service.

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Signature of Patient

Date

**\*\*Authorization for Treatment (if patient is under 18 years of age)\*\***

I do hereby consent, authorize, and request Student Health and Wellness Center personnel, and/or physician and/or mental health representative and/or other medical representative to whom referral is made, to conduct treatment which they may deem advisable in the event my son/daughter should require medical care while a student at the University of North Texas. I also agree to pay all charges incurred at the time of service.

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Signature of Parent or Legal Guardian

Date

**Patient Long-Term Signature Authorization**

The UNT Student Health and Wellness Center is aware that other departments on campus no longer require the use of your social security number. Please be advised that failure to provide your social security number to the Student Health and Wellness Center will significantly hinder the services available to you (including, but not limited to, filing insurance, lab work, x-rays, pharmacy and education). Your social security number will ONLY be used to provide and access medical services.

I am aware that the UNT Student Health and Wellness Center follows federal HIPAA guidelines in protecting my information. The Notice of Privacy Practices (NPP) describes my rights as a patient and how the SHWC may use my Protected Health Information (PHI) for treatment, payment, and operation. I may request a copy of the SHWC NPP at any time for review.

I hereby authorize the release of any medical information in order to process my medical insurance claim. I authorize payment of medical benefits to the UNT Student Health and Wellness Center on any third party payer medical insurance claims. I also authorize the Student Health and Wellness Center to release medical information as necessary for continuing treatments. The person giving this authorization may revoke such authorization at any time in writing. Photocopies of the authorization may be used in place of the original.

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Signature of Patient/Insured

Date