MEDICAL HISTORY

Please compete this form regarding allergies and medical history. Information supplied will become part of your health record and will be held in strict confidence. Its sole purpose is to enable medical staff to evaluate and help you with medical problems and to treat you appropriately should you become ill while at CSU. If at any time you wish others to have all or part of your records, it must be with your knoweldge and signed permission.

Name _____ Program ___Communications Institute @ CSU_____

ALLERGIES – Please list any allergies that you have and indicate if you carry an EpiPen:

Foods: _____

Medications: _____

Chemicals/Metals: _____

Other: _____

OTHER MEDICAL INFORMATION:

1. Have you ever been a patient in a hospital? Yes _____ No _____
   If so, when:

2. Have you had any operations? Yes _____ No _____
   Please list:

3. Have you had any serious injuries? Yes _____ No _____
   Please list:

4. Do you have any chronic illnesses? Yes _____ No _____
   Please list:

5. Are you currently on any medications? Yes _____ No _____
   Please list:

6. Are there any medical problems in your family? Yes _____ No _____
   Please list:

7. Have you had psychiatric treatment? Yes _____ No _____
   If so, when:

Please include a copy of Participant's Immunization Records