Return all information to:
Illinois Wesleyan University
Arnold Health Service
P0 Box 2900
Bloomington, IL 61702-2900

Arnold Health Service

Ph: (309) 556-3107 Fax: (309) 556-3805

This form is due:
August 1 for Fall Semester
December 1 for Spring Semester
and/or May Term

Gender: Male ❑ Female ❑ Trans ❑ Another ❑

Last Name (Print)	First Name	Middle	Preferred Name
Date of Birth	IWU Student ID Number	Email Address	Cell Phone Number

Home Address (Number and Street) City or Town State Zip Code

Parent or Guardian Cell Phone Number Home Telephone

Alternative Emergency Contact–Name, Relationship Cell Phone Number Home Telephone

MEDICAL HISTORY TO BE COMPLETED BY STUDENT

Allergies to Drug(s)/Medication(s) ❑ No ❑ Yes–*list* ____________________

Allergies to foods, nuts, insects, environmental ❑ No ❑ Yes–*list* ____________________

❑ **I am an intercollegiate athlete and I request the attached physical be released to the IWU Athletic Trainer Office**

Have you ever been diagnosed with any of the following? If Yes–*provide details below:*

	Yes	No		Yes	No		Yes	No
Anemia (including sickle cell anemia)			Epilepsy or other seizure disorder			Inflammatory bowel, Crohn's		
Arthritis			Fracture/Dislocation			Kidney or bladder infection, stone		
Asthma			Guillain Barre			Migraine headache		
Bleeding disorder			Head injury			Pneumonia		
Cancer (incl. Leukemia, Hodgkin's)			Heart mummer/Valve problem			Positive TB test/Tuberculosis		
Diabetes			High blood pressure			Psychiatric/Psychologist care		
Disordered eating (anorexia or bulimia)			Immunodeficiency disorder			Thyroid disorder		
Drug or alcohol dependency			Infectious mononucleosis			Serious accident or injury		

WOMEN'S HEALTH **MEN'S HEALTH**

Condition	Yes	No	Condition	Yes	No
Removal of breast lump or cyst/breast cancer			Lump or mass in testicle		
Missed periods more than four months					
Excessive flow					

FAMILY MEDICAL HISTORY

Check each item	Yes	No	Relationship		Yes	No	Relationship
Father living				Heart disease			
Mother living				High blood pressure			
Alcoholism				Nervous or mental disorder			
Cancer				Thyroid disease			
Diabetes				Tuberculosis			

Have you consulted or been treated by clinics, healthcare provider(s), healer(s) or other practitioners within the past five years? (Other than routine checkups.) ❑ Yes ❑ No If Yes–*provide details below:*

Details ____________________

Attach additional sheet if necessary

Signature of Student or Parent/Guardian (if under 18 years of age) Date

This information is strictly for the use of the Health Service and will not be released to anyone without your knowledge and written consent.