INDIANA UNIVERSITY SOUTH BEND

HEALTH AND WELLNESS CENTER

Vera Z. Dwyer College of Health Sciences

Health History

Please print the following information clearly:

Name_____**DOB**_____ **Age**_____

Address_____**City**_____**State**____ **Zip**_____

University ID # _____**Email (***IU email, if applicable***)**_____

Phone _____**Gender (***choose one***):**

Race _____**I am (***choose one***):**

Relationship (*choose one***):**

Do you have insurance? Yes( ) No( ) Type/Member ID _____

Personal Physician_____

Address _____ **Phone** _____

Preferred Pharmacy _____

Address_____**Phone** _____

Emergency contact:_____ **Relationship** _____ **Contact Number:** _____

Reason for today's visit:_____

Past medical history- Serious/chronic medical problems_____

_____

Hospital Admissions for medical illness- list year & condition _____

_____

Previous Surgeries- list date & operation _____

WOMEN: Are you or could you be pregnant? Yes( ) No( ) Due Date _____

Current Medications:

Prescription/Dosage _____

Over the Counter, herbal & alternative _____

Have you had your childhood vaccinations? Yes( ) No( ) Do you have a latex allergy: Yes( ) No( )

Allergies to medications & reactions: _____

Other allergies (*food, environmental,etc.***):** _____

I authorize Indiana University South Bend Health and Wellness Center to perform examinations, diagnostic tests and/or treatment as necessary.

_____ _____ _____

Print name **Signature** **Date**

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, IUSB Health and Wellness Center may use and disclose health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to IUSB's Health and Wellness Center Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. IUSB Health and Wellness reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at IUSB Health and Wellness Center; Vera Z. Dwyer Hall, 1960 Northside Blvd. South Bend, IN, 46615.

With my consent, IUSB Health and Wellness Center may do any of the following:

- **Call my home or designated location and leave a message on an answering machine or *in* person in reference to any items that assist the practice in carrying out TPO such as appointment reminder, cancellation, insurance items and any call pertaining to my clinical care, including certain lab results among others.**

- **Mail to my home or other designated location any items that assist the center in carrying out TPO, such as appointment reminder cards, lab results, as long as they are marked Personal and Confidential.**

- **Mail or fax to my home any forms which I ask the center to complete on my behalf.**

With my consent, IUSB Health and Wellness Center may, if they choose to do *so,* e-mail appointment reminder and patient statements to my designated address. I have the right to request that the Center restrict how it uses or discloses my PHI to carry out TPO. However, the center is not required to agree with my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, form consenting to IUSB Health and Wellness Centers' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the center has already made disclosures in reliance upon my prior consent. IF I DO NOT SIGN THIS CONSENT IUSB HEALTH AND WELLNESS CENTER MAY DECLINETO PROVIDE TREATMENT TO ME.

_____ _____

Signature **Date**

_____ _____

Print Name **Date of Birth**

Telephone: (574) 520-5557
Fax: (574) 520-5042