

UNIVERSITY OF WEST GEORGIA

University System of Georgia HEALTH FORM

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Address Office Phone Home Phone Office Phone Home Phone MEDICAL HISTORY Do you have or have you had any of the following? Allergies Yes No Diabetes Mellitus Yes No Epilepsy/Convulsions Yes No Asthma Yes No Heart Problems Yes No High Blood Pressure Yes No Do you receive allergy shots? Yes No Periods of Unconsciousness Yes No Reumatic Fever Yes No Are you allergic to: Surgical Operations Yes No No Hearting Eyes No No Hearting Impairment Yes No No Hearting Disability Yes No Chicken/Eggs Yes No Wisual or Hearting Impairment Yes No Learning Disability Yes No Penicillin Yes No Bleeding/Hemophilia Yes No Any Physical Disability Yes No Chief Drugs Yes No Bleeding/Hemophilia Yes No Any Physical Disability Yes No TREATMENT OF ANY CURRENT CONDITION TO CLINICAL DIRECTOR, WEST GEORGIA HEALTH CENTER, CARROLLTON, GA 30118. PLEASE LIST ANY DISABILITIES BECAUSE OF WHICH THE UNIVERSITY MAY NEED TO PROVIDE YOU WITH SPECIAL ASSISTANCE.	Address		Office Phone				
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If Yes, Date of Immunization				0			

The information on this form is confidential and will be used only in matters concerning your health. Mail completed form to the appropriate office: Health Services, University of West Georgia, Carrollton, Georgia 30118-4700.