UVA-WorkMed
1910 Arlington Blvd.
Charlottesville, VA 22903
Phone: 434-243-0075 Fax: 434-243-0078

Medical History Questionnaire

Name:_____ Date of Birth:____/____/____ E Mail:_____

Address:_____ City/State/Zip:_____

Phone#: (Home) _____ (Mobile) _____

Emergency Contact:_____ Relationship: _____ Phone #:_____

Primary Care Physician: _____
Please put a CHECK next to any of the following condition(s) that apply to you.

(1) Hearing Loss		(10) Poor Circulation		(19) Headaches	
(2) Vision Disorder		(11) Stomach Disorders		(20) Head Injury	
(3) Chronic Cough		(12) Tumors/Cancer		(21) Skin Disease	
(4) Breathing Disorder		(13) Arthritis		(22) Kidney/Urinary Disorder	
(5) Heart Attack		(14) Muscle Disorder		(23) Liver Disorder	
(6) Heart Failure		(15) Back Disorder		(24) Anxiety	
(7) Heart Pain		(16) Loss/Limited Use of Extremity		(25) Nervous Breakdown	
(8) Heart Valve Disorder		(17) Shoulder Problems		(26) Tuberculosis	
(9) High Blood Pressure		(18) Seizures			

27) Do you smoke? Yes ____No____ If yes, how many packs per day? _____
28) Do you consume alcoholic beverages? Yes ____ No ____ If yes, how many drinks per week ? _____
29) Do you currently use drugs such as marijuana, cocaine, or other similar or illegal drugs? Yes ____No____
30) Have you ever received treatment for or been recommended for treatment of alcoholism or drug abuse?
Yes _____ No _____

For above areas CHECKED or answered YES, please list number and explain: _____
_____
_____
_____

31) Do you have a disability? No _____ Yes _____ If yes, explain:_____
_____
32) Have you had any surgeries and/or hospitalizations? No ____ Yes _____ If yes, explain: _____
_____
_____

33) Do you have allergies? No _____ Yes _____ If yes, please list:_____
_____
34) Current medications (prescription and over the counter): _____
_____
_____

The purpose of this information is to establish a medical history. This is retained by UVA-WorkMed and becomes part of your medical record.

Signature: _____ Date: _____

Reviewed by:_____ Date:_____