

UVA-WorkMed - Medical History Questionnaire

Name: _____ Date of Birth: ____/____/____ SS#: _____

Address: _____ City/State/Zip: _____

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 _____ | 15) Muscle Disorder _____ |
| 2) Vision Disorder _____ | 16) Back Disorder _____ |
| 3) Chronic Cough _____ | 17) Loss/Limited Use of Extremity _____ |
| 4) Breathing Disorder _____ | 18) Shoulder Problems _____ |
| 5) Heart Attack _____ | 19) Seizures _____ |
| 6) Heart Failure _____ | 20) Headaches _____ |
| 7) Heart Pain _____ | 21) Head Injury _____ |
| 8) Heart Valve disorder _____ | 22) Skin disease _____ |
| 9) High Blood Pressure _____ | 23) Kidney/Urinary Disorder _____ |
| 10) Poor circulation _____ | 24) Liver Disorder _____ |
| 11) Stomach Disorders _____ | 26) Anxiety _____ |
| 12) Tumors/Cancer _____ | 27) Nervous Breakdown _____ |
| 13) Arthritis _____ | 28) Tuberculosis _____ |

- 29) Do you smoke? Yes _____ No _____ If yes, how many packs per day? _____
- 30) Do you consume alcoholic beverages? Yes _____ No _____ If yes, how many drinks per week? _____
- 31) Do you currently use drugs such as marijuana, cocaine, or other similar or illegal drugs? Yes _____ No _____
- 32) 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: _____

33) Do you have a disability? No _____ Yes _____ If yes, explain: _____

34) Have you had any surgeries and/or hospitalizations? No _____ Yes _____ If yes, explain: _____

35) Do you have allergies? No _____ Yes _____ If yes, please list: _____

36) 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: _____