



UVA-WorkMed
545 Ray C. Hunt Drive
Fontaine Research Park
Fax – 434-243-0078

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		(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: _____