UVA-WorkMed
P.O. Box 800357
Fontaine Research Park
Fax – 434-243-0078

Medical History Questionnaire

Name:_________________________________ Date of Birth:____/____/____ SS#:____________________

Address:____ City/State/Zip:_________________________

Phone#______________________________ Primary Care Physician_______________________________

Emergency Contact:_________________________ Relationship: ____________Phone #:_______________

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) Diabetes	

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 _______

31) . Have you ever been told you stop breathing during sleep? (Circle one)
(1) Never (2) Sometimes (<3 nights a week) (3) Often (3-7 nights a week (4) Uncertain

32) How often do you snore? (Circle one)
(1) Never (2) Moderate (<3 nights a week) (3) Most nights (3-7 nights a week) (4) Uncertain

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

34) Do you have a disability? No _____ Yes _____ If yes, explain:_______________________________
____

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

36) Do you have allergies? No _____ Yes _____ If yes, please list:_____________________________
____

37) 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:_____________________