University of Virginia HEALTH SYSTEM

MEDICAL HISTORY FORM

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR SCHEDULED APPOINTMENT AS WELL AS ALL YOUR MEDICATIONS AND ANY PRIOR MEDICAL RECORDS OR X-RAYS

PATIENT NAME

MR#

ADDRESSOGRAPH

Please assist in obtaining the most accurate information regarding your medical history by completing the information below. If you have already completed this form for our department, please disregard. Your assistance in greatly appreciated.

GENERAL INFOMATION: Date: _____

Name _____
LAST FIRST MIDDLE INITIAL

Home Address _____

_____
(CITY) (STATE) (ZIP CODE)

Home Phone ( ) _____ Work Phone ( ) _____

Date of Birth: _____ Social Security No. ___-___-___ Occupation _____

1. Who referred you to our clinic? (Name, Address and phone#) _____

_____

_____

2. What is the main reason for your visit today? _____

3. Height _____ Weight _____

4. Did you bring medical records, slides, and/or x-rays with you today? ☐ Yes ☐ No

MEDICAL HISTORY:

1. Please give the name, address and phone # of your medical/family Dr. and any referring Dr.'s you would like information sent to: _____

_____

_____

2. Do you have any known drug allergies? ☐ No ☐ Yes
   If yes, please list them on the reverse side of this form → Over to list Known Drug Allergies→
3. Do you take any medications? ☐ No ☐ Yes
   If yes, please refer to the back of this form to list all medications, when started, dosage, and how often medication is taken. (Please remember to list all over the counter medications taken also, i.e., Tylenol, Advil, Motrin,aspirin, vitamins etc.) →Over to list Current Medications→
4. Have you ever been hospitalized or had surgery? ☐ No ☐ Yes If yes, please list all previous surgeries and hospitalizations (include dates and hospitals when possible). Please see reverse side to list. →Over to list Hospitalization dates→
5. Do you have asthma? ☐ No ☐ Yes Smoker? ☐ No ☐ Yes Packs/Day _____ No. of Years _____
   Do you have breathing difficulties (i.e., shortness of breath, emphysema, etc.) ☐ No ☐ Yes
   Alcohol? ☐ No ☐ Yes Drinks/Day _____ Do you take recreational drugs? ☐ No ☐ Yes If answered yes to question #5 above, please explain: _____
6. Has your medical doctor ever treated you for any of the following conditions? If you answer yes to any of the medical conditions listed below, please describe and indicate when conditions started?

Diabetes (sugar):	☐ No	☐ Yes	If yes, do you take insulin. ☐ No ☐ Yes	
High blood pressure:	☐ No	☐ Yes	Started _____	Explain _____
Heart Disease	☐ No	☐ Yes	Started _____	Explain _____
Heart attack:(chest pain, irregular heart beat?)	☐ No	☐ Yes	Started _____	Explain _____
Headache/Migraine:	☐ No	☐ Yes	Started _____	Explain _____
Stroke:	☐ No	☐ Yes	Started _____	Explain _____
Weakness on one side:	☐ No	☐ Yes	Started _____	Explain _____
Seizure:	☐ No	☐ Yes	Started _____	Explain _____
Loss of consciousness:	☐ No	☐ Yes	Started _____	Explain _____
Eye problems:	☐ No	☐ Yes	Started _____	Explain _____
Bleeding problems:	☐ No	☐ Yes	Started _____	Explain _____
History of pain/medication:	☐ No	☐ Yes	Started _____	Explain _____
Skin problems:	☐ No	☐ Yes	Started _____	Explain _____

MEDICAL HISTORY FORM

SUMMARY SHEET

KNOWN DRUG ALLERGIES (List Below)

Today's Date	Name of Medication	Reaction to Medication When Taken

CURRENT MEDICATIONS (List Below)

Name of Medication	Date Started Medication	How Often Is It Taken	Reason for Taking Medication
1.			
2.			
3.			
4.			
5.			

HOSPITALIZATIONS (List Below)

Date of Hospitalization	Type of Surgery	Reason for Surgery
1.		
2.		
3.		
4.		
5.		

Reviewed by: ______________________________ Title ______________ Date ________

FOR CLINIC USE ONLY

DIAGNOSIS: **ACUTE PROBLEMS**

Problem	Medication Date			