Virginia Tech Carilion School of Medicine

Report of Medical History

C O N F I D E N T I A L

Please complete this form before going to your physician for examination

PERSONAL HISTORY (please check if you have had any of the following)

- ❑ Asthma
- ❑ Back Problem
- ❑ Cancer
- ❑ Chronic Fatigue
- ❑ Depression
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Head Injury/Concussion
- ❑ Hearing Problems
- ❑ Heart Problems
- ❑ HIV
- ❑ Hepatitis
- ❑ Intestinal Problems
- ❑ Migraine/Frequent Severe Headaches
- ❑ Seizure Disorder
- ❑ Alcohol/Substance Abuse
- ❑ Tuberculosis
- ❑ Smoke Cigarettes, Cigars, Pipe or Vape
- ❑ Vision Problems

Other medical, physical or psychological conditions that you believe we should be aware of? (Please explain)

_____

_____

Medication allergies_____

Have you ever been hospitalized? Had any operations? (Please note details) _____

_____

List all current medications_____

FAMILY HISTORY

	AGE	STATE OF HEALTH	AGE OF DEATH	CAUSE OF DEATH
Father				
Mother				
Brother(s)				
Sister(s)				

I hereby certify that the information submitted on this record is complete and correct.

Student Signature Date

Student Printed Name