Longwood University Health Center
106 Midtown Avenue . Farmville VA 23901
office 434.395.2102 fax 434.395.2783

HEALTH HISTORY

Name ____ Date of Birth: ___________________
Last First MI

MEDICAL HISTORY *(mark all that apply "C" for current; "P" for past)*

__ ADD/ADHD __ Allergies __ Anemia __ Anxiety __ Asthma __ Bleeding Disorder
__ Cancer _______ __ Concussion __ COVID-19 __Depression __ Diabetes
__ Eating Disorder __ Gastrointestinal Disorder __ Hearing Impairment __ Heart Disease
__ Heart Murmur __ Influenza __ Kidney infection __ Migraine __ Mononucleosis __ Pneumonia
__ Rheumatoid/Connective Tissue Disorder __ Seizure disorder __ STI __ Thyroid disorder
__ Tick borne illness __ Visual impairment __ Other

ALLERGIES: to medications, food, or environmental substance __ No __ Yes. List name(s) and reactions in space below

MEDICATIONS: List names, strength and frequency medications in space below.

Name of doctor(s) prescribing medications ____

SOCIAL HISTORY: *(mark all that apply)*
__ Tobacco __ Former smoker __ Vaping __ Alcohol __ Marijuana __ Illicit drug use
__ Caffeine intake ____________ ___ Exercise _______x weekly
__ Occupation (other than student) __________________________
-Are you on a special diet or have dietary restrictions? __ No __Yes_________________________
-Please feel free to discuss any concerns or questions you may have about your sexual health/practices or gender identity with your medical provider.

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Last First MI

FAMILY HISTORY: Using the medical history diagnoses above, list immediate family members and their diagnosis(es). If deceased then provide age of death.

PAST SURGICAL HISTORY: Please list surgeries or hospitalizations you have had. Include date and name of hospital.

OTHER: Anything you wish for your medical provider to know that has not already been reported?