LONGWOOD
UNIVERSITY

Patient Health History
Longwood University Health Services

NAME: ____DATE OF BIRTH: __________________
Last   First
PHONE:_________________________________ ADDRESS_______________________________________

Medical history: Have you ever been treated for any of the following medical conditions?

__ Arthritis
__ Diabetes
__ High blood pressure
__ Irritable bowel
__ Cancer

__ Osteoporosis
__ Depression/anxiety
__ Heart problem
__ Lung problem
__ Thyroid problem

Please list any other medical conditions:
____
____

Have you ever been hospitalized overnight? _____yes_____no   If yes, reason__________________________

Have you ever had surgery? _____yes_____no   If yes, reason______________________________________

Medications:____

Supplements/vitamins:____

Drug allergy:________________________ other healthcare allergy(latex,etc) ___________________________

Family history: Please list any known medical problems for the relatives listed below:
For example: diabetes, cancer, heart disease, high blood pressure, alcohol abuse, depression, osteoporosis

Mother:_______________________________________Father____________________________________

Brothers/sisters:____

Children:___________________________________ Other:_______________________________________

I hereby authorize the physician/ clinicians of Longwood University Student Health Center to examine, test, and treat me as they may deem advisable. There shall be no release of information to any person or agency without prior written agreement by me, unless required by law.

Patient Signature ______________________________________ Date ______________________