WVU Medicine
POTOMAC VALLEY HOSPITAL

Volunteer Health Screening

CONFIDENTIAL:

Name: ______________________________________ Phone: ________________________ Age: _________

Birthdate: _______________ Social Security #: ______________________ Physician: __________________

Physician's Address: ____

PHYSICAL QUESTIONNAIRE:

Have you had a TB Test? YES ____________ NO ______________ If yes, date _______________________

Results ____

Are you currently receiving medical treatment for any illness? YES ____________ NO _______________

If yes, please explain: ____

MEDICATIONS AND/OR TREATMENTS: ____

ALLERGIES (Please list): ____

IMMUNIZATIONS (Check yes or no and state year given)

Polio __ Yes __ No ___ Year Tetanus Booster __ Yes __ No ___ Year MMR __ Yes __ No ___ Year
Rubella __ Yes __ No ___ Year Hepatitis Vaccine __ Yes __ No ___ Year

PROFILE:

Chicken Pox	__ Yes	__ No	___ Year	Mumps	__ Yes	__ No	___ Year
Rubella (German or 3 Day)	__ Yes	__ No	___ Year	Asthma	__ Yes	__ No	___ Year
Measles (Rubeolla)	__ Yes	__ No	___ Year	Arthritis	__ Yes	__ No	___ Year
Scarlet Fever	__ Yes	__ No	___ Year	Anemia	__ Yes	__ No	___ Year
Emphysema	__ Yes	__ No	___ Year	Hepatitis	__ Yes	__ No	___ Year
Sickle Cell Anemia	__ Yes	__ No	___ Year	Cancer	__ Yes	__ No	___ Year
Tuberculosis	__ Yes	__ No	___ Year	Diabetes	__ Yes	__ No	___ Year
Exposure to Tuberculosis	__ Yes	__ No	___ Year	Epilepsy	__ Yes	__ No	___ Year
Rheumatic Fever	__ Yes	__ No	___ Year	Ulcer	__ Yes	__ No	___ Year
Kidney Disease	__ Yes	__ No	___ Year	Hernia	__ Yes	__ No	___ Year
Heart Disease	__ Yes	__ No	___ Year				
Thyroid Problem	__ Yes	__ No	___ Year				
High Blood Pressure	__ Yes	__ No	___ Year				

Date of last Physical: ____