

Patient Health History – Occupational Health Services

Name: _____ Date of Birth: _____

Employer: _____ Position: _____

History of past or present conditions- please check only if apply

<ol style="list-style-type: none">1. Allergies2. Asthma3. Arthritis4. Back Injuries5. Bladder Problems6. Blood Disease7. Chronic Back Pain8. Diabetes9. Emotional Disease10. Epilepsy11. Exposure to Chemicals, Dust, Noise, Fumes12. Fainting Spells	<ol style="list-style-type: none">13. Fractures14. Heart Trouble15. Head Injuries16. Hernia17. High Blood Pressure18. Hospitalization19. Injuries20. Jaundice21. Kidney Disease22. Lung Disease23. Mental Disease24. Missing appendages- Fingers, toes, arm etc	<ol style="list-style-type: none">25. Narcotic or habit forming drug use26. Operations27. Rheumatic Fever28. Serious Skin Problems29. Serious Infectious Disease- TB, Hepatitis, etc30. Stomach Problems31. Stroke32. Thyroid Disease33. Other _____
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Staff Comments:

Describe any other medical problems:
History of neck, back, shoulder, knee problems: Yes No
History of carpal tunnel problems (numbness, tingling of hands): Yes No
History of hernia problems: Yes No

Do you take any prescription drugs on a regular basis? No Yes- please list

Are you allergic to any-foods, medicines, or environmental items? No Yes-please list

Do you smoke? No Yes - How much? _____ How long? _____

Are you an ex-smoker? No Yes - When did you quit? _____

Do you drink alcohol? No Yes- if so, how much do you drink? _____

When was your last tetanus shot? _____

Who is your family physician? _____

When did you last see them? _____

Female applicants only: When was your last menstrual cycle? _____

Are you or do you think you are pregnant? Yes No

Have you ever or are you now collecting sickness/accident or workers comp? No Yes- Explain:

Occupational Work History:

	<u>Employer</u>	<u>Date</u>	<u>Job Description</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

The following to be signed by the applicant: I, the undersigned, hereby certify that all the information I have furnished on this form is true and correct. I willingly submit to any required tests necessary to complete this examination.

Applicant signature: _____ Date: _____

Reviewed by Occupational Health Staff: _____ Date: _____

Provider Signature: _____ Date: _____