OCCUPATIONAL AND MEDICAL HISTORY

(Please Print)

NAME: ____
First Middle Last

ADDRESS: ______________________________________ { } Male { }Female
Street

______________________________________ (____)__________________
City State Zip Telephone

DATE OF BIRTH: _________/_________/_________ **SOCIAL SECURITY #**: _________-_________-_________
Month Day Year

CURRENT MEDICATIONS (please include over-the-counter medications taken regularly):

____
(NOTE TO EXAMINER: Indicate whether or not medication might impair alertness on the job*)*

KNOWN ALLERGIES (please specify if none):

____
(*NOTE TO EXAMINER*: Document nature of allergic reaction and distinguish from medication adverse effect, such as G-I upset)

TOBACCO & ALCOHOL USE:
Describe current and past tobacco use (include # of packs per day, if & when quit, etc.) _________ never used

____

Describe current and past alcohol use (Include type, weekly quantity, if & when quit, etc.) _________ never used

____

IMMUNIZATION DATES:
Date of last Tetanus vaccine __________ Date Hepatitis B series completed _________ never had _________

FEMALES ONLY:
Are you or do you think you could be pregnant? Yes ________ No ________

First day of your last period ____

Most recent PAP smear & Gyn exam ____

Most recent breast exam by physician Most recent mammogram (if applicable) ____

MALES OVER 40 ONLY:
Do you have regular prostate evaluations by your personal physician? Yes __________ No __________

PAST MEDICAL HISTORY and SYMPTOM REVIEW

Have you ever or do you now have? (Check “Yes” or “No” and give “Year” if answer is “Yes”)

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Anemia or blood disease				Epilepsy/Seizures				Painful or bloody urination			
Arthritis				Eye trouble (other than glasses/contacts)				Unexplained weight gain or loss			
Allergies or asthma				Frequent colds or cough				Rheumatic fever			
Backache				Frequent or severe headaches				Shortness of breath			
Chronic bronchitis				Heart disease				Sinus trouble			
Cancer or tumor				Heart pain or angina				Skin disease			
Deafness or impaired hearing				Hepatitis or jaundice (liver trouble)				Stomach or duodenal ulcer			
Diabetes				Hernia or rupture				Thyroid disease			
Chronic diarrhea or bowel trouble				High blood pressure				Tuberculosis or chest disease			
Repeated dizziness or fainting spells				Joint problems				Varicose veins			
Drug or alcohol dependency				Kidney trouble or nephritis				Vomiting blood or black stools			
Emotional or psychiatric problems				Pneumonia				Chronic weakness or fatigue			

SURGERIES/HOSPITALIZATIONS

	Nature of Illness or Operation	Approximate Date	Duration of Illness
Operations			
Other hospitalization			

WORK HISTORY

Name of Company	Type of Work	Dates of Employment

Work-related injuries/illness while with previous employers? { } yes { } no (If yes, explain briefly)

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NOTE TO EXAMINER: Indicate whether or not the injury resulted in lost time, how much and whether or not residual impairment exists.

EXPOSURE HISTORY

Have you ever worked in or around:	Yes	No	Have you ever worked with or been exposed to:	Yes	No	Have you ever worked with or been exposed to:	Yes	No
1. Animals			Biologic Hazards			Physical Hazards		
2. Asbestos			Animals			Extreme heat/cold		
3. Chemicals			Insects			Radioactive materials (microwave, lasers, x-ray)		
4. Construction			Blood/blood products			Dusts (coal, sandblasting)		
5. Electronics			Infectious agents (bacteria, viruses)			Particulates (asbestos, silica)		
6. Hospital			Other			Noise (loud or continuous)		
7. Metals						Heavy lifting (50 lbs +)		
8. Mill (lumber, cotton, etc.)			Chemical Hazards			Repetitive motion		
9. Mine (coal, hematite)			Cytotoxic agents			Vibration		
10. Nuclear			Pesticides			Other		
11. Petroleum			Solvents					
12. Rubber			Other					
13. Sand pit/quarry								
14. Soot or tar								
15. Waste								
16. Other								

Explain all "Yes" answers in space below (include dates & years of exposure), especially noting whether any exposures resulted in obvious adverse effects (e.g., hearing loss, carpal tunnel syndrome, lead poisoning, etc.) and whether residual impairment exists.

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____

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Is there anything else in your medical history or any current symptoms or health concerns not covered above that you wish to discuss with the physician/medical examiner? Yes ________ No ________

Explain if "Yes":

____

____

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THE FOLLOWING TO BE SIGNED BY THE PATIENT: I the undersigned, hereby certify that all the information I have furnished on this form is true and correct. I authorize the examining physician to disclose to the client organization only information necessary for my employment status. This information is obtained from the details provided on this form and/or findings in the course of this examination. I willingly submit to any required tests necessary to complete this examination.

Employee/Applicant's Signature: ______________________________ **Date**: _______________

PATIENT - Please Do Not Write Below This Line

NOTE TO EXAMINER: Expand on items such as “Backache”, “Joint Problems” or other “Yes” responses or concerns which might impact on safe and effective job performance or pre-dispose to occupational injury.

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Examiner’s Signature: ____ **Date**: _______________