INTERVAL HISTORY FOR PERIODIC HEALTH EVALUATIONS

(Please Print)

NAME: _____ **DOB/CURRENT AGE:** _____/_____
First Middle Last

ADDRESS: _____
Street

_____ (____)_____
City State Zip Telephone

CURRENT EMPLOYER: _____ **SOCIAL SECURITY #**: _____-_____-_____

1. Since your last physical at The Occupational Health Center (OHC), have you had a significant illness or injury which required more than three (3) physician visits, a surgical procedure, extensive diagnostic testing, hospitalization, and/or resulted in more than three (3) days of lost work time? ***Yes_____*** ***No_____***

   Explain if "Yes", and describe whether or not you have residual symptoms and/or impairments as a result of this condition: _____
   _____
   _____

2. Are you currently under a doctor's care or seeing a physician regularly for anything other than routine physicals or episodic infections (colds, etc.)? ***Yes_____*** ***No_____***
   Explain if "Yes": _____
   _____
   _____

3. List all current prescription and over-the-counter medications including the dose and how often you take them:
   _____
   _____
   _____

4. Do you take any medication(s) which makes you drowsy or less alert? ***Yes_____*** ***No_____***
   Explain if "Yes": _____
   _____
   _____

5. List any known allergies to medications and/or environmental substances: ***None*** _____
   _____
   _____

6. If you smoke, describe how much and how long: ***Don't smoke*** _____
   _____

7. If you drink alcohol, describe what you drink and how much: ***Don't drink*** _____
   _____

8. What is your current job title and what are your duties?: _____
   _____

9. Since your last OHC physical, have you had any significant exposures at work (or at home) to chemicals, biological agents (bacteria, viruses, etc.), animals, radiation, or other hazardous or extreme working conditions which resulted in an obvious illness or injury? ***Yes_____ No_____***
   Explain if "Yes": _____
   _____
   _____

10. List any immunizations (Tetanus, Hepatitis, etc.) you've had since your last OHC physical: ***None_____***
    _____
    _____

11. FEMALES ONLY

    Are you or do you think you could be pregnant? ***Yes_____ No_____***

    First day of your last period: _____ Most recent PAP smear and GYN exam: _____

    Most recent breast exam by physician: _____ Most recent mammogram (if applicable): _____

12. MALES OVER 40 ONLY
    Do you have regular prostate evaluations by your personal physician? ***Yes_____ No_____***

13. Is there anything else in your medical history or any current symptoms or health concerns not covered above you wish to discuss with the physician/medical examiner? ***Yes_____ No_____***
    Explain if "Yes": _____
    _____
    _____

Employee Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE, FOR OFFICE USE ONLY

Reviewer's Comments: _____
_____
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Reviewer's Signature: _____ Date: _____