

Medical History (non comp services)

Please PRINT Clearly:

Date: _____ Time: _____

Employer: _____

Job "Function": _____

Please answer the following questions to the best of your ability:

List medication allergies _____ List current medications and dose: _____

List other allergies: _____ Over the counter drugs? _____

Medical Conditions? _____ Surgeries? _____

Work Injuries? _____

When was your last tetanus? _____ (Females) When was your last period? _____

What hand do you write with? Rt or Lt

Do you have, or have you ever had:

Y	N		Y	N		Y	N		Y	N	
		Night sweats /fever			Sinus problems			Bleed easily			Anemia
		Recent weight loss			Mouth sores			Blood disease			Diabetes
		Recent weight gain			Change in voice			Ulcers			Thyroid problems
		Convulsions /fits			Hoarseness			Change in bowel habit			Cancer
		Memory loss			Difficulty swallowing			Change in bladder habit			Change in wart or mole
		Numbness /tingling			Skin disease (list)			Hernia			Trouble sleeping
		Fainting /dizzy spell						Nausea /vomiting			Stress
		Headache						Blood in urine			Depression
		Paralysis			Heart problems			Kidney problem			Prior drug treatment
		Stroke /blood clot			Chest pain			Reproductive problem			Prior alcohol treatment
		Wear glasses?			Rheumatic fever			Bladder infection			Hay fever
		_for reading			Irregular heart beat			Reproductive infection			Asthma
		_for distance			Heart murmur			Broken bones			Bronchitis
		_contact lenses			High blood pressure			Smoked? # of years__			Pneumonia
		Color blindness			Swollen ankles			_Quit? Date			Tuberculosis
		Glaucoma			Varicose veins			_Cigarettes #packs/day			Persistent cough
		Vision problems			Shortness of breath			_cigars # /day			Cough up blood
		Hearing problems			Average alcohol intake			_pipe #bowls/day			Back injury
		Noise in ears			_per day			Drug use			Joint injury /pain
		Balance problems			_per week						Arthritis

Patient Comments:

Examiner _____

Please **PRINT** Clearly:

Patient Name: _____

Work History

Name of company	Type of work	Dates of employment

Have you ever worked with or been exposed to:

	Yes	No		Yes	No		Yes	No
Animals/insects			Petroleum			Noise (loud or continuous)		
Particulates (asbestos/silica)			Mill (lumber, cotton)			Heavy lifting (50 lbs or >)		
			Mine (coal, hematite)			Repetitive Motion		
Construction			Rubber/Latex			Vibration		
Chemicals:			Sand pit/Quarry			Extreme Heat or Cold		
Cytotoxic agents			Nuclear/Radioactive			Blood/blood products		
Pesticides			Radiation (lasers, x-ray, microwaves)			Infectious agents (Bacteria or viruses)		
Solvents			Waste			Other _____		
Metals			Other _____			Other _____		

Family History

	General Health	Age	Medical Problems
Father			
Mother			
Brother(s)			
Sister(s)			
Father's Father			
Father's Mother			
Mother's Father			
Mother's Mother			

Comments:

 /

Examiner Printed Name/Signature

Date

The preceding statements are true to the best of my knowledge and I understand this will become part of my employee medical record. I understand that an incorrect statement is ground for release.

 Signature of Applicant

 Date