MEDICAL AND OCCUPATIONAL HISTORY

NAME _____ **DOB** _____ **MALE /FEMALE** Circle

EMPLOYER _____ **JOB TITLE** _____ **PHYSICIAN** _____

ALLERGIES: _____

_____

LAST TETANUS _____

HEPATITIS B SERIES _____

CURRENT MEDICATIONS:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE CHECK YES OR NO IF YOU HAVE OR HAVE HAD ANY OF FOLLOWING:

☐ YES	☐ NO	BRONCHITIS	☐ YES	☐ NO	HARD OF HEARING
☐ YES	☐ NO	ASTHMA	☐ YES	☐ NO	RINGING IN EARS
☐ YES	☐ NO	EMPHYSEMA	☐ YES	☐ NO	DRAINAGE FROM EARS
☐ YES	☐ NO	FREQUENT COUGH	☐ YES	☐ NO	RECENT CHANGE IN VISION
☐ YES	☐ NO	BLOODY PHLEGM	☐ YES	☐ NO	COLOR BLIND
☐ YES	☐ NO	PNEUMONIA	☐ YES	☐ NO	GLAUCOMA
☐ YES	☐ NO	PLEURISY	☐ YES	☐ NO	WEAR GLASSES/CONTACTS
☐ YES	☐ NO	CHEST PAIN	☐ YES	☐ NO	SINUS TROUBLE
☐ YES	☐ NO	FREQUENT SHORTNESS OF BREATH	☐ YES	☐ NO	HAY FEVER
☐ YES	☐ NO	HIGH BLOOD PRESSURE	☐ YES	☐ NO	FREQUENT COLDS
☐ YES	☐ NO	HEART MURMUR	☐ YES	☐ NO	THYROID PROBLEMS
☐ YES	☐ NO	HEART DISEASE	☐ YES	☐ NO	DIFFICULTY SWALLOWING
☐ YES	☐ NO	RHEUMATIC FEVER	☐ YES	☐ NO	KIDNEY PROBLEMS
☐ YES	☐ NO	SWELLING IN ANKLES	☐ YES	☐ NO	FREQUENT URINATION
☐ YES	☐ NO	CIRCULATION PROBLEMS	☐ YES	☐ NO	PAINFUL URINATION
☐ YES	☐ NO	VARICOSE VEINS	☐ YES	☐ NO	KIDNEY STONES
☐ YES	☐ NO	TUBERCULOSIS	☐ YES	☐ NO	BLOODY URINE
☐ YES	☐ NO	NIGHT SWEATS	☐ YES	☐ NO	BLADDER/KIDNEY INFECTIONS
☐ YES	☐ NO	FREQUENT HEADACHES	☐ YES	☐ NO	SKIN RASH
☐ YES	☐ NO	FAINTING SPELLS	☐ YES	☐ NO	SKIN LUMPS
☐ YES	☐ NO	CONVULSIONS SEIZURES	☐ YES	☐ NO	SKIN CHANGES
☐ YES	☐ NO	LOSS OF MEMORY	☐ YES	☐ NO	CANCER
☐ YES	☐ NO	LOSS OF APPETITE	☐ YES	☐ NO	DIABETES
☐ YES	☐ NO	WEIGHT GAIN/LOSS GREATER THAN 10LBS	☐ YES	☐ NO	TROUBLE SLEEPING
☐ YES	☐ NO	STOMACH ULCER	☐ YES	☐ NO	CLAUSTROPHOBIA
☐ YES	☐ NO	FREQUENT HEARTBURN	☐ YES	☐ NO	DEPRESSION
☐ YES	☐ NO	COLITIS	☐ YES	☐ NO	ARTHRITIS
☐ YES	☐ NO	HEPATITIS	☐ YES	☐ NO	PAINFUL/SWOLLEN JOINTS
☐ YES	☐ NO	FREQUENT NAUSEA/VOMITING	☐ YES	☐ NO	BACK PAIN /INJURY
☐ YES	☐ NO	ABDOMINAL PAIN	☐ YES	☐ NO	NECK PAIN/INJURY
☐ YES	☐ NO	BLOODY OR BLACK STOOLS	☐ YES	☐ NO	SHOULDER PAIN/INJURY
☐ YES	☐ NO	FREQUENT DIARRHEA	☐ YES	☐ NO	WRIST PAIN/INJURY
☐ YES	☐ NO	FREQUENT CONSTIPATION	☐ YES	☐ NO	ELBOW PAIN/INJURY
☐ YES	☐ NO	HERNIA	☐ YES	☐ NO	KNEE PAIN/INJURY
☐ YES	☐ NO	HEMORRHOIDS	☐ YES	☐ NO	DISC PROBLEMS
☐ YES	☐ NO	GALLSTONES	☐ YES	☐ NO	ORTHOPEDIC BRACES
			☐ YES	☐ NO	TENDONITIS
			☐ YES	☐ NO	NUMBNESS/TINGLING IN HANDS/FEET

LIST ANY SURGERIES _____

LIST ANY BROKEN BONES_____

COMMENTS _____

_____

HEALTHWORKS

BEGINNING WITH CURRENT JOB, LIST ALL JOBS HELD IN LAST 5 YEARS

EMPLOYER	JOB TITLE	APPROX. DATES	KNOWN HEALTH HAZARDS

IN YOUR PAST JOBS WERE YOU EXPOSED TO ANY OF THE FOLLOWING

	YES	NO	UNSURE	COMPANY	DUTIES
CHEMICALS					
FUMES/VAPORS/GASES					
TEMPERATURE EXTREMES					
NOISE					
HEAVY LIFTING					
RADIATION					
INFECTIOUS DISEASE					
ASBESTOS					
DUST					
OTHER					

Do you have any condition which you will require special working arrangements ? □ NO
□ YES (EXPLAIN) _____

Have you lost time from work due to illness or injury during the last 5 years? NO □
□ YES (EXPLAIN) _____

Are you partially disabled in any way? □ NO □ YES (EXPLAIN) _____

Have you ever been advised to have an operation you did not have ? □ NO
□ YES (EXPLAIN)_____

□ YES □ NO Do you drink two or more alcoholic drinks a day ? _____

□ YES □ NO Do you use recreational drugs? _____

□ YES □ NO Do you exercise daily ? _____

□ YES □ NO Do you smoke? How much ? How long ? If formally smoked when did you quit?

I CERTIFY THAT THE INFORMATION GIVEN BY ME ON THIS FORM IS TRUE AND ACCURATELY REFLECTS MY MEDICAL HISTORY, FALSIFICATION OR OMISSION MAY BE GROUNDS FOR DISIPLINARY ACTION UP TO AND INCLUDING TERMINATION

_____ _____
PATIENT SIGNATURE **DATE**

PROVIDER COMMENTS

_____
_____
_____
_____

HEALTHWORKS MEDICAL PROVIDER REVIEW

_____ _____
PROVIDER SIGNATURE **DATE`**