MEDICAL AND OCCUPATIONAL HISTORY

UR MEDICINE | THOMPSON HEALTH

Name:
Date of Birth:
Phone:
Address:
Employer:
Job Title:
Primary Care Provider:
Last Tetanus:
Hepatitis B Series/Titer:
Allergies (Meds, food, environmental, seasonal):

Current Medications: No Medications

Name	Dose	Frequency

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

Y N

CONSTITUTIONAL
- Recent Weight Gain > 10lbs.
- Recent Weight Loss > 10lbs.
- Loss of Appetite

SKIN
- Skin Rash/Lumps
- Skin/Mole Changes
- Skin Ulcers
- Psoriasis/Eczema

EYES
- Recent Change in Vision
- Color Blindness
- Glaucoma
- Wear Glasses/Contacts
- "Lazy Eye"

ENT
- Hay fever/Allergies
- Hearing Loss/Aids
- Drainage from Ears
- Frequent Sinus Problems
- Frequent Sore Throat

CARDIOVASCULAR
- Chest Pain
- High Blood Pressure
- Heart Murmur
- Heart Disease / Surgery
- Swelling in Ankles
- Frequent Shortness of Breath
- Varicose Veins
- Circulation Problems
- Rheumatic Fever
- Irregular Heart Rhythm/Afib
- Pacemaker/Stent/Defibrillator
- Valve Replacement
- Heart Attack/MI
- Elevated Cholesterol
- Clotting Disorder/Blood Thinners

RESPIRATORY
- Bronchitis
- Asthma
- COPD/Emphysema

Y N

- Frequent Cough
- Bloody Phlegm
- Pneumonia
- Pleurisy
- Tuberculosis (TB)
- Positive TB Test
- Night Sweats
- Sleep Apnea/CPAP use
- Pulmonary Embolism

GASTROINTESTINAL
- Difficulty Swallowing
- GERD/Heartburn
- Gallstones
- Hepatitis
- Stomach Ulcer
- Frequent Nausea/Vomiting
- Abdominal Pain
- Bloody or Black Stools
- Frequent Diarrhea
- Frequent Constipation
- Hernia (Groin, Hiatal, Abdominal)
- Hemorrhoids
- Crohn's Disease
- Ulcerative Colitis

GENITOURINARY
- Kidney Problems
- Frequent Urination
- Painful Urination
- Kidney Stones
- Bloody Urine
- Bladder Infections (UTI)
- Kidney Infections (Pyelonephritis)
- Kidney Failure/Dialysis
- Endometriosis
- Ovarian Cysts

MUSCULOSKELETAL
- Arthritis
- Painful/Swollen Joints
- Back Pain/Injury/Disc Problems
- Neck Pain/Injury
- Shoulder Pain/Injury
- Wrist Pain/Injury

Y N

- Elbow Pain/Injury
- Knee Pain/Injury
- Foot/Ankle Pain/Injury
- Tendonitis
- Fibromyalgia
- Osteoporosis
- Missing/Limited use of Hand/Arm/Leg/Foot

NEUROLOGICAL
- Tremors
- Headaches/Migraines
- Dizziness or Fainting
- Seizures/Epilepsy
- Memory Loss
- Numbness/Tingling
- Loss of Strength/Paralysis
- Stroke/TIA/Mini-Stroke
- Concussion/Brain Trauma
- Multiple Sclerosis

PSYCHIATRIC
- Claustrophobia
- Depression
- Bipolar
- Anxiety
- ADHD/ADD
- Trouble Sleeping
- PTSD
- Schizophrenia

ENDOCRINE
- Diabetes Type 1/Type 2
- Insulin Use
- Thyroid Disorder
- Adrenal Disorder
- Parathyroid Disorder

OTHER
- COVID-19
- Lyme Disease
- Cancer (Specify)
- Autoimmune (Specify)

Name: DOB:

List any surgeries:
List any broken bones:
List any other hospitalizations:

BEGINNING WITH YOUR 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					

YES NO

Do you have any conditions which will require special working arrangements?
If yes, explain:
Have you lost time from work due to illness or injury during the last 5 years?
If yes, explain:
Are you partially disabled in any way?
If yes, explain:
Have you ever been advised to have an operation you did not have?
If yes, explain:
Do you drink two or more alcoholic drinks a day?
Do you exercise daily?
Do you smoke? How much? How long?
If former smoker, 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 disciplinary action up to and including termination.

Patient Signature: Date:

Provider Comments:

Provider Signature: Date: