Business and Employee Health Services

AT MERCY

COMPREHENSIVE MEDICAL AND OCCUPATIONAL HEALTH HISTORY QUESTIONNAIRE

SITE: _____

Please answer all questions accurately and completely.

IDENTIFICATION DATE: Fill in the following information. PLEASE PRINT. Today's Date _____/_____/_____

_____ _____/_____/_____ Age:_____ Sex: ☐ Male ☐ Female

Name Date of Birth (Month / Day / Year)

_____ – _____ – _____ ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Social Security Number Education: _____years Elementary _____years High School

_____years College, Technical, Business, etc.

_____

Home Address

_____ _____

City State Zip Code Employer / Department Previously Employed: ☐ Yes ☐ No

_____ _____

Home Telephone (area code) Occupation / Position Applied For

YOUR HEALTH HISTORY: Mark an **X** in the box next to any of the following illnesses you now have or have ever had.

☐ Anemia
☐ Asthma
☐ Back / Musculoskeletal Problems
☐ Bleeding Tendencies
☐ Bronchitis
☐ Cholesterol / Other Blood Fat Problems
☐ Diabetes
☐ Diverticulosis
☐ Emphysema
☐ Eye Problems
☐ Glaucoma
☐ Hay Fever or Allergies
☐ Headaches (recurrent)
☐ Hearing Trouble
☐ Heart Attack
☐ Heart Trouble (other)
☐ Hemorrhoids
☐ Hernias
☐ High Blood Pressure
☐ Hives or Rashes
☐ Hospitalizations
☐ Kidney / Bladder trouble
☐ Liver disease / Hepatitis
☐ Mental Health Problems
☐ Neuralgia / Neuritis (unexplained pain)
☐ Pneumonia
☐ Rheumatic Fever
☐ Rheumatism / Arthritis
☐ Seizures
☐ Stroke / Mini-Stroke
☐ Substance Abuse
☐ Surgery
☐ Trauma (fall, mva, assault)
☐ Tuberculosis / TB Skin Test
☐ Veneral Disease
☐ Work Related Injury / Illness
☐ Other Chronic Disorders

_____

Do you have any phobias? _____ ☐ Yes ☐ No

Have you ever been turned down for life insurance, military service or employment because of health problems? _____ ☐ Yes ☐ No

Have you ever received a blood transfusion? _____ ☐ Yes ☐ No

If ever incarcerated, do you have any reason to believe that you may have acquired an infectious/communicable disease that needs to be evaluated or possibly treated? _____ ☐ Yes ☐ No

Name and Phone # of Personal Physician: _____

YOUR EXPOSURE HISTORY: Your continued good health is important to you, your family and to us. With this in mind, we would like you to give us some basic information about your previous work and leisure time activities.

Please mark an **X** in either the ***Yes*** or ***No*** box following each of the items listed below.

	YES	NO	HOW LONG?
1. Dust			
2. Welding and soldering fumes			
3. Exhaust from engines			
4. Noise			
5. Heat			
6. Aircraft engines			
7. Heavy gunfire			
8. Cold			
9. Unusual stress			

Have you ever worked in a:	YES	NO	HOW LONG?
1. Steel mill			
2. Coal mine			
3. Chemical plant			
4. Other heavy industry			

Notes:

Have you ever worked with:	YES	NO	HOW LONG?
1. Arsenic			
2. Asbestos			
3. Benzene			
4. Beryllium			
5. Cadmium and its compounds			
6. Carbon Disulfide			
7. Carbon Monoxide			
8. Carbon Tetrachloride			
9. Cement Dust			
10. Chloride			
11. Chrome compounds			
12. Cutting and Soluble Oils			
13. Expoxy resins			
14. Fibrous glass			
15. Fluorides			
16. Hydrogen Sulfide			
17. Lead			
18. Other heavy metals			
19. Microwaves			
20. Pesticides			
21. Phenol			
22. Phosgene			
23. Radioactive Substances			
24. Solvents			

Do you have, or have you ever had a hobby involving:

	YES	NO	HOW LONG?
1. Compressed Air (diving)			
2. Engine Exhaust			
3. Loud Noise (shooting, cycling)			
4. Paints, Solvents, Glues			
5. Other Chemicals_____			
6. Other Exposures_____			

Notes:

SOCIAL AND PHYSICAL ACTIVITY: Mark an **X** in the box ***Yes*** or ***No*** in answer to the following questions. Fill in the blanks where necessary.

I. SMOKING

Do you smoke? _____ ☐ Yes ☐ No

Cigarettes Cigars Pipe

How many cigarettes a day_____ How many cigars a day_____ Pipe - How often per day_____

Have you ever smoked? _____ ☐ Yes ☐ No

How many years? _____ When did you quit? _____

Do you chew tobacco? _____ ☐ Yes ☐ No

II. DRUGS AND ALCOHOL

Do you now or have you ever used drugs? _____ ☐ Yes ☐ No

Do you drink beer, wine or hard liquor _____ ☐ Yes ☐ No

Average less than 1 drink per day _____ ☐ Yes ☐ No

Average 2 or more drinks per day _____ ☐ Yes ☐ No

III. PHYSICAL ACTIVITY

How often to you engage in brisk activity that lasts at least 20 minutes?

☐ Rarely ☐ 1 - 2 times per week ☐ 3 or more times a week

Type: ☐ walking ☐ jogging ☐ biking ☐ other (specify)

☐ swimming ☐ weight lifting ☐ stair machine

YOUR CURRENT HEALTH STATUS: Please mark an **X** in the box next to the following questions.

	Yes	No
Do you have any problems with concentration or memory?	☐	☐
Is your weight stable?	☐	☐
If no, have you gained or lost more than 10 pounds in the last three months?	☐	☐
Do you get at least 5 hours sleep most nights (days)?	☐	☐
Are you generally in a good mood?	☐	☐
During the past two weeks, have you felt down, depressed or hopeless?	☐	☐
During the past two weeks, have you felt little interest or pleasure in doing things?	☐	☐
Do you have any problems with your eyes, ears, nose or throat?	☐	☐
Do you have any problems with your hearing or vision?	☐	☐
Do you have headaches more than once or twice a month?	☐	☐
Have you had any problems with cough, congestion or shortness of breath?	☐	☐
Have you had problems with chest pain?	☐	☐
Do you have dizzy or lightheaded episodes?	☐	☐
Have you ever passed out (fainted)?	☐	☐
Has there been any change in your appetite?	☐	☐
Do you have a problem with nausea, diarrhea or constipation?	☐	☐
Do you have any problem with abdominal (belly) pain?	☐	☐
Have you ever had blood or mucus in your stool?	☐	☐
Do you have a problem with passing your stool?	☐	☐
Do you have a problem with passing your urine?	☐	☐
Have you had any problems with your joints or muscles?	☐	☐
Have you ever had neck or back problems?	☐	☐
Have you ever had an injury to your neck, back, extremities or joints?	☐	☐
Have you ever had any brocken bones?	☐	☐
Do you have a problem with weakness (loss of strength)?	☐	☐
Do you have numbness or tingling in your extremities?	☐	☐
Have you ever had problems with your breasts; pain, lumps, nipple discharge?	☐	☐
Have you ever had any skin problems?	☐	☐
Do you have any unusual lumps or bumps on your skin?	☐	☐
Have you ever been physically or sexually abused?	☐	☐
Have you seen a physician or other healthcare provider more than 2 times in the past 12 months?	☐	☐
FOR WOMEN ONLY:		
Are your menstrual periods regular?	☐	☐
Have they changed in the past two years?	☐	☐
Do you regularly have menstrual cramps?	☐	☐
Are they disabling - that is, do they keep you from performing your activities of daily living, going to work?		

TESTS: Mark an **X** next to those tests which you have had within the last three years.

☐ Chest X-ray	☐ Electrocardiogram / EKG	☐ Hearing Test
☐ Kidney X-ray	☐ Electrocardiogram with Exercise / Stress	☐ Back X-ray
☐ GI Series	☐ TB Skin Test	☐ C-T Scan
☐ Colon X-ray	☐ Breathing Test	☐ MRI
☐ Gallbladder Study	☐ Biopsy	☐ Blood Tests
☐ Other_____	☐ Other_____	☐ Other_____

IMMUNIZATIONS: Mark an **X** next to the immunizations you have had. Enter the year when you were last given the test.
Mark an **X** after those immunizations to which you know you had a serious reaction.

Year		Reaction	Year		Reaction
☐ 19___	20___ Tetanus / Diphtheria (DTP)_____	☐	☐ 19___	20___ Measles, Mumps, Rubella (MMR)_____	☐
☐ 19___	20___ Polio _____	☐	☐ 19___	20___ Hepatitis A_____	☐
☐ 19___	20___ Influenza _____	☐	☐ 19___	20___ Hepatitis B (Full Series)_____	☐
☐ 19___	20___ Travel Immunizations _____	☐	☐ 19___	20___ Pneumococcal _____	☐
☐ 19___	20___ BCG / Tuberculosis Vaccination _____	☐	☐ 19___	20___ Typhoid _____	☐
☐ 19___	20___ PPD - TB Skin Test_____	☐			

MEDICINES:

Do you have a history of sensitivity to medicine? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No

Mark an **X** in the box next to any medications that you are now taking and/or are now sensitive to.

Now Taking		Sensitive To
☐	aspirin	☐
☐	penicillin	☐
☐	sulfa	☐
☐	codeine	☐
☐	antibiotics	☐
☐	sedatives	☐
☐	sinus medications	☐
☐	laxatives	☐
☐	cold tablets	☐
☐	diet pills	☐
☐	heart medicines	☐
☐	high blood pressure	☐

Now Taking		Sensitive To
☐	Dilantin / anticonvulsants	☐
☐	birth control pills	☐
☐	diuretics / water pills	☐
☐	blood thinners / anticoagulants	☐
☐	steroids (e.g., Cortisone)	☐
☐	insulin / diabetic pills	☐
☐	anti-inflammatories (e.g., Motrin, Advil, Ibuprofen)	☐
☐	pain medication (narcotics)	☐
☐	tranquillizers	☐
☐	anti-depressants	☐
☐	Other _____	☐

PROVIDER COMMENTS:

PLEASE READ THE FOLLOWING CAREFULLY:

1. I hereby certify that the answers and explanations to all preceding questions are true and complete to the best of my knowledge. I realize that any falsification or concealment of facts may result in termination of my employment.

2. I agree to have a per-placement or initial examination, tuberculin skin test, blood and urine test, chest x-ray and other tests deemed necessary prior to employment and at subsequent intervals to be determined by the BEHS/COBOMS/PSI staff.

3. I hereby consent to allow the performance of breath and/or fluid testing for alcohol and/or drugs.

<u>Your blood and/or urine will not be used for AIDS testing.</u>

I understand that all information given in this questionnaire is retained in my confidential medical record. I understand that only information related to my ability to perform the essential functions of my position will be released to my employer.

_____ _____

Signature Date Provider Signature Date