Business and Employee Health Services
AT MERCY

COMPREHENSIVE MEDICAL AND OCCUPATIONAL HEALTH HISTORY QUESTIONNAIR

06300

SITE: _____

Please answer all questions accurately and completely.

IDENTIFICATION DATA: Fill in the following information. PLEASE PRINT. Today's Date ___/___/___

_____ Name

_____/_____/_____Age: ____ Sex: ☐ Male ☐ Female
Date of Birth (Month/Day/Year)

_____ Social Security Number

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Education: _____ Elementary _____ High School

_____ Home Address

_____ College, Technical, Business, etc.

_____ Graduate School

_____ City State Zip Code

_____ 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.

Yes	No		Yes	No	
☐	☐	Allergies or Hay Fever	☐	☐	Kidney / Bladder Trouble
☐	☐	Anemia	☐	☐	Kidney Stones
☐	☐	Ankle Weakness	☐	☐	Knee Problems
☐	☐	Appendicitis	☐	☐	Leg Cramps
☐	☐	Asthma	☐	☐	Leukemia
☐	☐	Back Pain / Musculoskeletal Problems	☐	☐	Liver Disease / Hepatitis
☐	☐	Bleeding Tendencies	☐	☐	Loss of Memory
☐	☐	Blood in Urine	☐	☐	Lung Disease
☐	☐	Bone or Joint Deformity	☐	☐	Malaria
☐	☐	Bowel Problems	☐	☐	Mental Health Problems
☐	☐	Breast Disease	☐	☐	Migraine
☐	☐	Bronchitis	☐	☐	Mononucleosis
☐	☐	Cancer	☐	☐	Mumps
☐	☐	Chest Pains	☐	☐	Muscle Weakness
☐	☐	Chicken Pox	☐	☐	Narcolepsy
☐	☐	Cholesterol / Other Blood Fat Problems	☐	☐	Neck Pain / Problems
☐	☐	Chronic Cough	☐	☐	Nervous Breakdown
☐	☐	Cirrhosis of the Liver	☐	☐	Nervousness
☐	☐	Claustrophobia	☐	☐	Neuralgia / Neuritis (unexplained pain)
☐	☐	Cold or Painful Fingers	☐	☐	Paralysis
☐	☐	Constipation	☐	☐	Personality Changes
☐	☐	Convulsions	☐	☐	Pneumonia
☐	☐	Dental or Gum Problems	☐	☐	Pneumothorax
☐	☐	Depression or Excessive Worry	☐	☐	Poliomyelitis
☐	☐	Diabetes	☐	☐	Polio

If you have not answered YES or NO to any of the conditions above, then you affirm that condition does not apply to you.

_____ Patient/Employee Print

_____ Patient/Employee Signature

YOUR HEALTH HISTORY CONTINUED

Yes	No		Yes	No	
☐	☐	Diarrhea	☐	☐	Rheumatic Fever
☐	☐	Difficulty Sleeping	☐	☐	Rheumatism / Arthritis
☐	☐	Difficulty in Breathing	☐	☐	Scarlet Fever
☐	☐	Diverticulosis	☐	☐	Seizures
☐	☐	Dizziness / Fainting	☐	☐	Sexual Problems
☐	☐	Ear Disease / Problem	☐	☐	Sexually Transmitted Disease
☐	☐	Edema in foot or leg	☐	☐	Shortness of Breath
☐	☐	Elbow Trouble	☐	☐	Shoulder Trouble
☐	☐	Emphysema	☐	☐	Sickle Cell Disease
☐	☐	Epilepsy or Seizures	☐	☐	Silicosis
☐	☐	Eye Problems or Injury	☐	☐	Sinus Trouble
☐	☐	Eye Surgery	☐	☐	Skin Disease
☐	☐	Fainting or Unconsciousness	☐	☐	Stomach or Ulcer Problem
☐	☐	Fever	☐	☐	Stroke / Mini-Stroke
☐	☐	Fertility Problems	☐	☐	Substance Abuse
☐	☐	Foot Trouble	☐	☐	Surgery
☐	☐	Frequent Colds and Sore Throat	☐	☐	Swollen Joints
☐	☐	Gallstones	☐	☐	Thyroid Problems
☐	☐	Glasses or Contact Lenses	☐	☐	Tonsillitis
☐	☐	Glaucoma	☐	☐	Trauma (Fall, MVA, Assault)
☐	☐	Gonorrhea	☐	☐	Tremor of Hands or Head
☐	☐	Hair Loss	☐	☐	Trouble Smelling Odors
☐	☐	Headaches (recurrent)	☐	☐	Tuberculosis / TB Skin Test
☐	☐	Hearing Problems or Loss	☐	☐	Tumors or cysts
☐	☐	Heart Attack	☐	☐	Ulcers
☐	☐	Heart Trouble (other)	☐	☐	Unexplained Weight Gain
☐	☐	Hemorrhoids	☐	☐	Unexplained Weight Loss
☐	☐	Hernias	☐	☐	Unusual Weakness
☐	☐	Herpes	☐	☐	Urinary Problems
☐	☐	High Blood Pressure	☐	☐	Uterine or Ovarian Disease
☐	☐	Hives or Rashes	☐	☐	Varicose Veins
☐	☐	Hospitalizations	☐	☐	Venereal Disease
☐	☐	Indigestion	☐	☐	Visual Problems
☐	☐	Jaundice	☐	☐	Work Related Injury / Illness
☐	☐	Joint Problems			

Other: _____

Any claims for compensation or disability? ☐ Yes ☐ No

If yes, explain: _____

_____

Have you ever been turned down for Life Insurance, Military Service, or Employment due to Health Problems? ☐ Yes ☐ No

If yes, explain: _____

_____

Are you now or have you ever been handicapped? ☐ Yes ☐ No

Do you have any phobias? ☐ 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

If you have not answered YES or NO to any of the conditions above, then you affirm that condition does not apply to you.

_____ _____

Patient/Employee Print Patient/Employee Signature

Have you ever applied or received VA Medical Benefits? ☐ Yes ☐ No

Please explain: _____

_____

List any surgeries, please include age and year: _____

_____

List any hospitalizations, please include age and year: _____

Have you ever been hurt on any job? ☐ Yes ☐ No

If yes, list year(s), type of injury, and any therapy: _____

Have you ever been injured in any type of vehicle accident(s): ☐ Yes ☐ No

If yes, please explain: _____

Have you ever received any treatment for alcohol or drug use? ☐ Yes ☐ No

Are there any details about your health history that have not been addressed in this questionnaire?

_____

_____

Are you allergic to any of the following?

- ☐ Animal Dander or Feathers
- ☐ Foods
- ☐ House Dust
- ☐ Medications
- ☐ Metal, Jewelry
- ☐ Other Allergies
- ☐ Pollens
- ☐ Drugs/Medications
- ☐ Serum
- ☐ Sunlight
- ☐ Vaccines

If yes, please explain: _____

MEDICINES:

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

Are you currently taking any medication? ☐ Yes ☐ No

Mark an X in the box next to any medications that you are now taking, have taken in the past month and/or are now sensitive to.

- ☐ Amphetamines
- ☐ Antacids
- ☐ Antibiotics
- ☐ Anticoagulants
- ☐ Antidepressants
- ☐ Antihistamines
- ☐ Anti-inflammatory (e.g. Motrin, Advil, Ibuprofen)
- ☐ Appetite Suppressants
- ☐ Aspirin
- ☐ Benzedrine
- ☐ Birth Control Pills
- ☐ Blood Pressure Medications
- ☐ Codeine
- ☐ Cold Tablets
- ☐ Diabetic Medications
- ☐ Diet Pills
- ☐ Dilantin / Anticonvulsants
- ☐ Diuretics / Water Pills
- ☐ Heart Medication
- ☐ High Blood Pressure
- ☐ Hormones
- ☐ Insulin / Diabetic
- ☐ Pain Medication (narcotics)
- ☐ Laxatives
- ☐ Morphine
- ☐ Penicillin
- ☐ Sedatives
- ☐ Sinus Medication
- ☐ Sleeping Pills
- ☐ Steroids (e.g. Cortisone)
- ☐ Sulfa Medications
- ☐ Thyroid Medication
- ☐ Tranquilizers
- ☐ Tylenol
- ☐ Vitamins
- ☐ Other

Please list any medication that you are presently taking that is not included on the list: (This includes over the counter medications)

If you have not answered YES or NO to any of the conditions above, then you affirm that condition does not apply to you.

_____ _____

Patient/Employee Print Patient/Employee Signature

_____

_____

Please list all medications that you are sensitive to that are not included on the list: (This includes over the counter medications)

_____

_____

YOUR EXPOSURE HISTORY: Your continued good health is important to 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. Have you ever worked with, or were you exposed to any of the items listed below? Please mark an X in either the Yes or No box, and if yes state how long.

	Yes	No	How Long?
Acetic Acid	☐	☐	_____
Acetone	☐	☐	_____
Acetylene	☐	☐	_____
Aircraft Engines	☐	☐	_____
Alkalis	☐	☐	_____
Alkyl Chloride	☐	☐	_____
Ammonia	☐	☐	_____
Ammonium Persulfate	☐	☐	_____
Antimony	☐	☐	_____
Arsenic	☐	☐	_____
Asbestos	☐	☐	_____
Bacteria or viruses	☐	☐	_____
Benzene	☐	☐	_____
Beryllium	☐	☐	_____
Boron Trichloride	☐	☐	_____
Cadmium and its compounds	☐	☐	_____
Carbon Disulfide	☐	☐	_____
Carbon Monoxide	☐	☐	_____
Carbon Tetrachloride	☐	☐	_____
Cement Dust	☐	☐	_____
Chlorates	☐	☐	_____
Chloride	☐	☐	_____
Chlorinated Hydrocarbons	☐	☐	_____
Chlorine	☐	☐	_____
Chlorosilanes	☐	☐	_____
Chrome compounds	☐	☐	_____
Lindane (cotton industry)	☐	☐	_____
Mercury	☐	☐	_____
Methanol	☐	☐	_____
Methyl Bromide	☐	☐	_____
Methyl Ethers	☐	☐	_____
Methylene Chloride	☐	☐	_____
Microwaves	☐	☐	_____
Nitric Acid	☐	☐	_____
Nitrogen Oxide	☐	☐	_____
Nitrous Oxide	☐	☐	_____
Noise	☐	☐	_____
Organic Arsenic	☐	☐	_____
Organic Peroxides	☐	☐	_____
Oxalic Acid	☐	☐	_____
PCB's	☐	☐	_____
Pesticides	☐	☐	_____
Petroleum Products	☐	☐	_____
Phenol	☐	☐	_____
Phosgene	☐	☐	_____
Phosphoric Acid	☐	☐	_____
Phosphorus Oxychloride	☐	☐	_____
Primate Animals	☐	☐	_____
Radiation or Radioactive substances	☐	☐	_____

	Yes	No	How Long?
Chromium	☐	☐	_____
Coke Oven Emissions	☐	☐	_____
Cold	☐	☐	_____
Crystalline Silica	☐	☐	_____
Cutting and Soluble Oils	☐	☐	_____
Cyanide	☐	☐	_____
Dust	☐	☐	_____
Electrical Shock	☐	☐	_____
Epoxy resins	☐	☐	_____
Ethylene Glycol	☐	☐	_____
Excessive Noise	☐	☐	_____
Exhaust from Engines	☐	☐	_____
Fibrous glass	☐	☐	_____
Fluorides	☐	☐	_____
Florine, Hydrazine	☐	☐	_____
Fluorocarbons	☐	☐	_____
Formaldehyde	☐	☐	_____
Heat	☐	☐	_____
Heavy Gunfire	☐	☐	_____
Helium	☐	☐	_____
Herbicides	☐	☐	_____
Hydrogen Sulfide	☐	☐	_____
Inorganic Fluorides	☐	☐	_____
Insecticides	☐	☐	_____
Isocyanates	☐	☐	_____
Lead	☐	☐	_____
Silica	☐	☐	_____
Silicon Tetrachloride Acid	☐	☐	_____
Solvents	☐	☐	_____
Sulfuric	☐	☐	_____
Sulphus Dioxide	☐	☐	_____
Suspected / Known Carcinogens	☐	☐	_____
TDI	☐	☐	_____
Tolulene	☐	☐	_____
Tolulene Diisocynate	☐	☐	_____
Toxapenes	☐	☐	_____
Trichloroethane	☐	☐	_____
Trichloroethylene	☐	☐	_____
Unusual Stress	☐	☐	_____
Vibrating Tools	☐	☐	_____
Vinyl Chloride	☐	☐	_____
Welding and Soldering Fumes	☐	☐	_____
Xylene	☐	☐	_____
Other heavy metals	☐	☐	_____

If you have not answered YES or NO to any of the conditions above, then you affirm that condition does not apply to you.

_____ _____

Patient/Employee Print Patient/Employee Signature

Have you ever worked in a:

Yes	No	
☐	☐	Steel Mill
☐	☐	Coal Mine
☐	☐	Chemical Plant
☐	☐	Other Heavy Industry

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

Yes	No	
☐	☐	Compressed Air (Diving)
☐	☐	Engine Exhausts
☐	☐	Loud Noise (Shooting, Cycling)
☐	☐	Paints, Solvents, Glues
☐	☐	Other Chemicals _____
☐	☐	Other Exposures _____

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? _____ How much did you smoke per day? _____

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

How many beers do you drink each week? _____

How many glasses of wine do you drink each week? _____

Do you drink more than a fifth of hard liquor each week? ☐ Yes ☐ No

How much hard liquor do you drink each week? _____

III. PHYSICAL ACTIVITY

How often do 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 five 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 problem 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 pains?	☐	☐
Do you have dizzy or lightheaded episodes?	☐	☐
Have you ever passed out (fainted)?	☐	☐

If you have not answered YES or NO to any of the conditions above, then you affirm that condition does not apply to you.

_____ _____

Patient/Employee Print Patient/Employee Signature

YOUR CURRENT HEALTH STATUS CONTINUED

Has there been any change in your appetite?	☐	☐
Do you have a problem with nausea, vomiting, diarrhea or constipation?	☐	☐
Do you have any problem with abdominal (belly) pain?	☐	☐
Have you ever had blood or mucous 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 broken 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 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	☐			

PROVIDER COMMENTS:

If you have not answered YES or NO to any of the conditions above, then you affirm that condition does not apply to you.

_____ Patient/Employee Print

_____ Patient/Employee Signature

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 pre-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.

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

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

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

If you have not answered YES or NO to any of the conditions above, then you affirm that condition does not apply to you.

_____ _____

Patient/Employee Print Patient/Employee Signature