



**BUSINESS HEALTH SERVICES
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 ____/____/____

Name

____/____/____ **Age** ____ **Sex** Male Female

Social Security Number

Married Separated Divorced Widowed Single
Education: _____ years in Elementary _____ years in High School
_____ years in 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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches (recurrent) | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Back/Musculoskeletal Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatism/Arthritis |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Hearing Trouble (other) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stroke/Mini-Stroke |
| <input type="checkbox"/> Cholesterol/Other Blood Fat Problems | <input type="checkbox"/> Hernias | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hives or Rashes | <input type="checkbox"/> Trauma (fall, mva, assault) |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Tuberculosis/TB Skin Test |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Kidney/Bladder trouble | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Health Problems | <input type="checkbox"/> Other Chronic Disorders |
| <input type="checkbox"/> Hay Fever or Allergies | <input type="checkbox"/> Neuralgia/Neuritis (unexplained pain) | <input type="checkbox"/> _____ |

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 infections/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 us, 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			

	YES	NO	How Long?
1. Steel mill			
2. Coal mine			
3. Chemical plant			
4. Other heavy industry			

Notes:

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

	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. Epoxy 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			

Have you ever worked with:

	YES	NO	How Long?
1. Compressed Air (diving)			
2. Engine Exhausts			
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 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.

- Do you have any problems with concentration or memory? Yes No
- Is your weight stable? Yes No
- If no, have you gained or lost more than 10 pounds in the last three months? Yes No
- Do you get at least five hours sleep most nights (days)? Yes No
- Are you generally in a good mood? Yes No
- During the past two weeks, have you felt down, depressed or hopeless? Yes No
- During the past two weeks, have you felt little interest or pleasure in doing things? Yes No
- Do you have any problems with your eyes, ears, nose or throat? Yes No
- Do you have any problem with your hearing or vision? Yes No
- Do you have headaches more than once or twice a month? Yes No
- Have you had any problems with cough, congestion or shortness of breath? Yes No
- Have you had problems with chest pains? Yes No
- Do you have dizzy or lightheaded episodes? Yes No
- Have you ever passed out (fainted)? Yes No
- Has there been any change in your appetite? Yes No
- Do you have a problem with nausea, vomiting, diarrhea or constipation? Yes No
- Do you have any problem with abdominal (belly) pain? Yes No
- Have you ever had blood or mucous in your stool? Yes No
- Do you have a problem with passing your stool? Yes No
- Do you have a problem with passing your urine? Yes No
- Have you had any problems with your joints or muscles? Yes No
- Have you ever had neck or back problems? Yes No
- Have you ever had an injury to your neck, back, extremities or joints? Yes No
- Have you ever had any broken bones? Yes No
- Do you have a problem with weakness (loss of strength)? Yes No
- Do you have numbness or tingling in your extremities? Yes No
- Have you ever had problems with your breast; pain, lumps, nipple discharge? Yes No
- Have you ever had any skin problems? Yes No
- Do you have any unusual lumps or bumps on your skin? Yes No
- Have you ever been physically or sexually abused? Yes No
- Have you seen a physician or other healthcare provider more than 2 times in the past 12 months? Yes No

FOR WOMEN ONLY:

- Are your menstrual periods regular? Yes No
- Have they changed in the past two years? Yes No
- Do you regularly have menstrual cramps? Yes No
- Are they disabling – that is, do they keep you from performing your activities of daily living, going to work? Yes No

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

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Electrocardiogram/EKG | <input type="checkbox"/> Hearing Test |
| <input type="checkbox"/> Kidney X ray | <input type="checkbox"/> Electrocardiogram with Exercise/Stress | <input type="checkbox"/> Back X-ray |
| <input type="checkbox"/> GI Series | <input type="checkbox"/> TB Skin Test | <input type="checkbox"/> C-T Scan |
| <input type="checkbox"/> Colon X-ray | <input type="checkbox"/> Breathing Test | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Gallbladder Study | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Blood Tests |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> 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 |
|-----------------------------------|---|-----------------------------------|---|
| <input type="checkbox"/> 19__20__ | Tetanus/Diphtheria (DTP) <input type="checkbox"/> | <input type="checkbox"/> 19__20__ | Measles, Mumps, Rubella (MMR)..... <input type="checkbox"/> |
| <input type="checkbox"/> 19__20__ | Polio <input type="checkbox"/> | <input type="checkbox"/> 19__20__ | Hepatitis A..... <input type="checkbox"/> |
| <input type="checkbox"/> 19__20__ | Influenza <input type="checkbox"/> | <input type="checkbox"/> 19__20__ | Hepatitis B (Full Series)..... <input type="checkbox"/> |
| <input type="checkbox"/> 19__20__ | Travel Immunizations..... <input type="checkbox"/> | <input type="checkbox"/> 19__20__ | Pneumococcal..... <input type="checkbox"/> |
| <input type="checkbox"/> 19__20__ | BCG/Tuberculosis Vaccination <input type="checkbox"/> | <input type="checkbox"/> 19__20__ | Typhoid..... <input type="checkbox"/> |
| <input type="checkbox"/> 19__20__ | PPD-TB Skin Test <input type="checkbox"/> | | |

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 and/or are now sensitive to.

- | Now Taking | Sensitive To |
|--|--------------------------|
| <input type="checkbox"/> aspirin | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | <input type="checkbox"/> |
| <input type="checkbox"/> sulfa | <input type="checkbox"/> |
| <input type="checkbox"/> codeine | <input type="checkbox"/> |
| <input type="checkbox"/> antibiotics | <input type="checkbox"/> |
| <input type="checkbox"/> sedatives | <input type="checkbox"/> |
| <input type="checkbox"/> sinus medications | <input type="checkbox"/> |
| <input type="checkbox"/> laxatives | <input type="checkbox"/> |
| <input type="checkbox"/> cold tablets | <input type="checkbox"/> |
| <input type="checkbox"/> diet pills | <input type="checkbox"/> |
| <input type="checkbox"/> heart medicines | <input type="checkbox"/> |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> |

- | Now Taking | Sensitive To |
|--|--------------------------|
| <input type="checkbox"/> Dilantin/anticonvulsants | <input type="checkbox"/> |
| <input type="checkbox"/> birth control pills | <input type="checkbox"/> |
| <input type="checkbox"/> diuretics/water pills | <input type="checkbox"/> |
| <input type="checkbox"/> blood thinners/anticoagulants | <input type="checkbox"/> |
| <input type="checkbox"/> steroids (e.g.: Cortisone) | <input type="checkbox"/> |
| <input type="checkbox"/> insulin / diabetic pills..... | <input type="checkbox"/> |
| <input type="checkbox"/> anti-inflammatories..... | <input type="checkbox"/> |
| (e.g.: Motrin, Advil, Ibuprofen) | |
| <input type="checkbox"/> pain medication (narcotics)..... | <input type="checkbox"/> |
| <input type="checkbox"/> tranquilizers | <input type="checkbox"/> |
| <input type="checkbox"/> anti-depressants..... | <input type="checkbox"/> |
| <input type="checkbox"/> other | <input type="checkbox"/> |

PROVIDER COMMENTS:

PLEASE READ THE FOLLOWING CAREFULLY

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.

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 by the BEHSI staff.

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