OCCUPATIONAL HEALTH CENTER
HEALTH HISTORY

Name:_____ **DOB:**_____**SSN:**_____

Family Physician:_____

PERSONAL HISTORY Do you have, or have you ever had any of the following: (check each box yes or no)								
	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Deafness or hearing problems			Loss of appetite, chronic			Goiter or thyroid trouble		
Ear, nose or throat problems			Prostate trouble			Recent weight gain or loss		
Chest pain or angina			Venereal disease			Anemia or blood disease		
Chest surgery			Arthritis or rheumatism			Blood coughed up or vomited		
Heart trouble			Backache or leg pain			Cancer, tumor, cyst or growth		
High blood pressure			Foot problems			Claustrophobia		
Palpitation or pounding heart			“Locked knee” or trick joint”			Depression or excessive worry		
Allergies, asthma, hay fever			Swelling of ankles or feet			Drug/alcohol abuse		
Collapsed lung			Swollen or painful joints			Fatigue, chronic or severe		
Chronic cough			Carpal tunnel syndrome			Frequent trouble sleeping		
Emphysema			Numbness of arms or hands			Reaction from medication		
Pleurisy			Tingling of arms or hands			Weakness		
Pneumonia			Tingling of legs or feet			Tuberculosis		
Shortness of breath			Convulsions, fits or seizures			Latex Allergy		
Wheezing in chest			Dizziness or fainting spells			Rubella		
Gallbladder trouble			Epilepsy			Measles		
Hernia or rupture			Headaches, frequent/chronic			Mumps		
Hemorrhoids or rectal trouble			Nervous trouble of any sort			Scarlet or Rheumatic Fever		
Stomach trouble, ulcers			Skin rash or hives			Jaundice, hepatitis, liver disease		
Frequent or painful urination			Chills, fever, night sweats			Varicella (chicken pox)		
Kidney trouble/blood in urine			Diabetes, sugar in urine					

IF YOU CHECKED “YES” IN ANY OF THE PERSONAL HISTORY BOXED ABOVE, PLEASE EXPLAIN FURTHER:

Name of employer requiring physical_____ **Dept.**_____**Job Title**_____

Patient ID

	Yes	No
Have you ever worn a respirator?	☐	☐
Did you experience difficulty wearing it?	☐	☐
How long have you worked in your department?_____		

How Often Does Your Job Require You to Wear a Respirator?

- ☐ Daily Basis
- ☐ Over 4 hours per day
- ☐ Under 4 hours per day
- ☐ 2-3 times a weeks
- ☐ Rarely or for emergency use

DO YOU HAVE A HANDICAP RECOGNIZED BY THE INDUSTRIAL COMMISSION OF OHIO (If yes, please check box)

- ☐ **1. Epilepsy**
- ☐ **2. Diabetes**
- ☐ **3. Cardiac Disease**
- ☐ **4. Arthritis**
- ☐ **5. Amputated foot, leg, arm, or hand**
- ☐ **6. Loss of sight of one or both eyes or a partial loss of vision of more than 75% bilaterally**
- ☐ **7. Residual disability from poliomyelitis**
- ☐ **8. Cerebral Palsy**
- ☐ **9. Multiple Sclerosis**
- ☐ **10. Parkinson's Disease**
- ☐ **11. Tuberculosis**
- ☐ **12. Silicosis**
- ☐ **14. Psycho-neurotic disability following treatment in a recognized medical or mental institution.**
- ☐ **15. Hemophilia**
- ☐ **16. Chronic Osteomyelitis**
- ☐ **17. Ankylosis of Joints**
- ☐ **18. Hyper Insulinism**
- ☐ **19. Muscular Dystrophies**
- ☐ **20. Arteriosclerosis**
- ☐ **21. Thrombophlebitis (blood clots)**
- ☐ **22. Varicose Veins**
- ☐ **23. Cardiovascular and pulmonary disease of a fire fighter. Employed by a municipal corporation or township as a regular member of a lawfully constituted fire department**.

FOR WOMEN ONLY

PLEASE CHECK EACH BOX YES OR NO AND COMPLETE BELOW	Yes	No	**IF YES, PLEASE EXPLAIN**
Have you ever had any breast injury or disease?	☐	☐	
Have you ever been treated for a female disorder?	☐	☐	
Date of last period_____			
Duration of period _____days			
Interval between periods _____days			
Number of pregnancies_____			
Number of term deliveries_____			
Date of last pap smear_____			

Patient ID

PLEASE CHECK ANY INJURIES YOU HAVE HAD					
	Fractures/Broken Bones		Dislocations		Loss of consciousness/head injury
	Severe Burns		Back injury		Loss of arm, leg, finger, toe
	Severe Cuts		Low back pain		

IF YOU HAVE HAD SURGERY OR HAVE BEEN HOSPITALIZED FOR THE LISTED INJURIES ABOVE, PLEASE EXPLAIN:

PLEASE CHECK IF YOU HAVE BEEN IMMUNIZED FOR ANY OF THE FOLLOWING					
	Tetanus		Polio		Rubella/Rubeola (measles)
	Smallpox		Hepatitis B		Other:
			Hepatitis A		

Have you ever had a positive reaction to a Tuberculosis (PPD) test? Yes No (circle one)

If yes when? _____ Was any treatment recommended? _____

PLEASE CHECK EACH BOX YES OR NO	Yes	No		
Do you drink caffeine? (coffee, tea, soft drinks)			How many cups per day?	
Do you drink alcoholic beverages?			How many oz. per day?	
Would you like information on alcohol abuse or how to quit drinking?				
Do you smoke now?			How many per day?	For how many years?
Would you like information on quitting smoking?				
Did you ever smoke?			How many years ago?	How long did you smoke?
Do you currently use other types of tobacco?				
Do you use illegal drugs or abuse legal drugs?				
Would you like information on how to quit taking illegal or legal drugs?				

Patient ID

		HAVE YOU EVER OR ARE YOU: (Check each box Yes or No)
YES	**NO**	
		1. Had any time off work in the past two years due to illness or injury?
		2. Presently under a health professional's care? (Physician, chiropractor, etc.)
		3. Been discharged or disqualified from the armed services for any medical reason?
		4. Served in the military? (If yes, give dates and location)
		5. Been treated for a work related injury?
		6. Been unable to perform certain tasks at work because of sensitivity to chemicals, dust, sunlight?
		7. Been unable to perform certain tasks at work because of inability to perform certain motions?
		8. Been unable to perform certain tasks at work because of inability to assume certain position?
		9. Been unable to perform certain tasks at work because of inability to lift certain amounts of weight?
		10. Been unable to perform certain tasks at work because of medical reasons such as angina, heart disease.
		11. Been a patient in a hospital or sanitarium? (If yes, list facility and reason for hospitalization)
		12. Had surgery recommended or performed?
		13. Been turned down on a physical examination or informed of any abnormal findings on a physical examination?
		14. Worn a brace or support?
		15. Are you claustrophobic? (Fear of small enclosed spaces)
		16. Are you acrophobic? (Fear of heights)

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN FURTHER:

The job for which I am applying has been explained to me and I believe I am physically able to perform the essential job functions. I have answered the questions on this Health History Form and they are true and correct to the best of my knowledge.

Signature_____Date_____

Patient ID