Comprehensive Care
Occupational Medicine Specialists

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Health Questionnaire

Date:	Last Name:	First Name:	Pre-Fix	Date of Birth:	Social Security #:

Phone #:	Street Address:	City:	State:	Zip Code:

Statement of Patient's Present Health and Medications Currently Used (use additional pages if necessary)

Present Health	Current Medications	Regular or Interm.
Allergies:		
Tetanus: Yes ☐ No ☐ When:		

Past / Current Medical History

Check Each Item	*Yes*	*No*	*???*	*Check Each Item*	*Yes*	*No*	*???*
1) Household contact with anyone with tuberculosis	☐	☐	☐	43) Frequent indigestion	☐	☐	☐
2) Tuberculosis or positive TB test	☐	☐	☐	44) Stomach, liver or intestinal trouble	☐	☐	☐
3) Blood in sputum or when coughing	☐	☐	☐	45) Gall bladder trouble or gallstones	☐	☐	☐
4) Excessive bleeding after injury or dental work	☐	☐	☐	46) Jaundice or hepatitis	☐	☐	☐
5) Suicide attempt or plans	☐	☐	☐	47) Broken bones	☐	☐	☐
6) Sleepwalking	☐	☐	☐	48) Adverse reaction to medication	☐	☐	☐
7) Wear corrective lenses	☐	☐	☐	49) Skin diseases	☐	☐	☐
8) Eye surgery to correct vision	☐	☐	☐	50) Tumor, growth, cyst or cancer	☐	☐	☐
9) Lack vision in either eye	☐	☐	☐	51) Hernia	☐	☐	☐
10) Wear a hearing aid	☐	☐	☐	52) Hemorrhoids or rectal disease	☐	☐	☐
11) Stutter or stammer	☐	☐	☐	53) Frequent or painful urination	☐	☐	☐
12) Wear a brace or back support	☐	☐	☐	54) Bed wetting since age 12	☐	☐	☐
13) Scarlet fever	☐	☐	☐	55) Kidney stone or blood in urine	☐	☐	☐
14) Rheumatic Fever	☐	☐	☐	56) Diabetic (Sugar or albumin in urine)	☐	☐	☐
15) Swollen or painful joints	☐	☐	☐	57) Sexually transmitted diseases	☐	☐	☐
16) Frequent or severe headaches	☐	☐	☐	58) Recent gain or loss of weight	☐	☐	☐
17) Dizziness or fainting spells	☐	☐	☐	59) Eating disorder (anorexia, bulimia, etc.)	☐	☐	☐
18) Eye trouble	☐	☐	☐	60) Arthritis, rheumatism or Bursitus	☐	☐	☐
19) Hearing loss	☐	☐	☐	61) Thyroid trouble or goiter	☐	☐	☐
20) Recurrrent ear infections	☐	☐	☐	62) Bone, joint or other deformity	☐	☐	☐
21) Chronic or frequent colds	☐	☐	☐	63) Loss of finger or toe	☐	☐	☐
22) Severe tooth or gum trouble	☐	☐	☐	64) Painful or "trick" shoulder or elbow	☐	☐	☐
23) Sinusitis	☐	☐	☐	65) Recurrent back pain or any back injury	☐	☐	☐
24) Hay fever or allergic rhinitis	☐	☐	☐	66) "Trick" or locked knee	☐	☐	☐
25) Head injury	☐	☐	☐	67) Foot trouble	☐	☐	☐
26) Asthma	☐	☐	☐	68) Nerve Injury	☐	☐	☐
27) Shortness of breath	☐	☐	☐	69) Paralysis (including infantile)	☐	☐	☐
28) Pain or pressure in chest	☐	☐	☐	70) Epilepsy or seizure	☐	☐	☐
29) Chronic cough	☐	☐	☐	71) Car, train, sea or air sickness	☐	☐	☐
30) Palpitation or pounding heart	☐	☐	☐	72) Frequent trouble sleeping	☐	☐	☐
31) Heart trouble	☐	☐	☐	73) Depression or excessive worry	☐	☐	☐
32) High or low blood pressure	☐	☐	☐	74) Loss of memory or amnesia	☐	☐	☐
33) Cramps in your legs	☐	☐	☐	75) Nervous trouble of any sort	☐	☐	☐
34) Periods of unconsciouness	☐	☐	☐	76) Plate, pin or rod in any bone	☐	☐	☐
35) Parent / Sibling with diabetes, cancer, stroke or heart disease	☐	☐	☐	77) Easy Fatigability	☐	☐	☐
36) X-ray or other radiation therapy	☐	☐	☐	78) Been told to cut down or criticized for alcohol use	☐	☐	☐
37) Chemotherapy	☐	☐	☐	79) Used illegal substances	☐	☐	☐
38)Asbestos or toxic chemical exposure	☐	☐	☐	80) Used tobacco	☐	☐	☐
39) Gout	☐	☐	☐	81) Metal Implants	☐	☐	☐
40) Anemia	☐	☐	☐	82) Fractures / Dislocations	☐	☐	☐
41) Pacemaker	☐	☐	☐	83) Chemical Dependency	☐	☐	☐
42) Multiple Sclerosis	☐	☐	☐	84) Respiratory Problems	☐	☐	☐

85) Hepatitis A	☐	☐	☐	87) Hepatitis C	☐	☐	☐
86) Hepatitis B	☐	☐	☐	88) Typhoid Fever	☐	☐	☐

If you answered **"YES"** to any of the previous questions, please explain in as much detail as possible:

Question #: Explanation:

Height: ____________________ Urinalysis → Spec. Gravity: ____________________

Weight: ____________________ pH: ____________________

BP: ____________________ Alb: ____________________

Pulse: ____________________ Sugar: ____________________

Respiration: ____________________ Ketone: ____________________

Temperature: ____________________ Blood: ____________________

Vision Check			
Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye	20 /	20 /	degrees
Left Eye	20 /	20 /	degrees
Both Eyes	20 /	20 /	degrees

Check Each Item (females only)	*Yes*	*No*	*???*	Date of last menstrual period	Date of last PAP Smear	Date of last Mammogram
Treated for a female disorder	☐	☐	☐			
Change in menstrual period	☐	☐	☐			

Check each item. If "YES" explain in the blank space to the right (list explanation by item number)

Item	*Yes*	*No*	*Please provide explanations in this section*
1) Have you been refused employment or been unable to hold a job or stay in school because:			
a. Sensitivity to chemicals, dust, sunlight, etc.	☐	☐	
b. Inability to perform certain motions	☐	☐	
c. Inability to assume certain positions	☐	☐	
d. Other medical reasons (if yes, give reasons)	☐	☐	
2) Have you ever been treated for a mental condition (if yes, be specific with details)	☐	☐	
3) Have you ever been denied life insurance	☐	☐	
4) Have you had or been advised to have an operation	☐	☐	
5) Have you ever been a patient in any type of hospital	☐	☐	
6) Have you consulted or been treated by clinics, physicians, or practitioners within the past 5 years for other than minor illnesses	☐	☐	
7) Have you ever been rejected for military service because of physical, mental or other reasons	☐	☐	
8) Have you ever been discharged from military service because of physical, mental or other reasons	☐	☐	
9) Have you ever received, is there pending, or have you ever applied for pension or compensation for an existing disability	☐	☐	
10) Have you ever been diagnosed with a learning disability	☐	☐	

Based on the information provided within this Health Questionnaire by the patient as well as the vitals, urinalysis performed and the results of the job demand analysis, this individual qualifies for:

☐ Approved to perform the duties set forth per the JOB DESCRIPTION

☐ Does NOT meet the requirements to perform the duties set forth per the JOB DESCRIPTION

Physician's summary and elaboration of all pertinent data		
Name of Patient	Signature	Date
Name of Clinician	Signature	Date