Comprehensive Care
Occupational Medicine Specialists

Address: 7501 West 15th Avenue
Gary, Indiana 46406
Phone #: (219) 977-2090
Fax #: (219) 977-2091
Web Address: compcareonline.com

Report of Medical History

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

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

Physician:	Company:	Patient's Occupation	Examination Type:

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

Present Health	Current Medications	Regular or Interm.

Allergies (include insect bites / strings & common foods)		Additional Information	
		Height:	Are You: ☐ Right Handed
		Weight:	☐ Left Handed

Past / Current Medical History

Check Each Item	*Yes*	*No*	*???*	*Check Each Item*	*Yes*	*No*	*???*
01) Household contact with anyone with tuberculosis	☐	☐	☐	34) Frequent indegestion	☐	☐	☐
02) Tuberculosis or positive TB test	☐	☐	☐	35) Stomach, liver or intestinal trouble	☐	☐	☐
03) Blood in sputum or when coughing	☐	☐	☐	36) Gall bladder trouble or gallstones	☐	☐	☐
04) Excessive bleeding after injury or dental work	☐	☐	☐	37) Jaundice or hepatitis	☐	☐	☐
05) Suicide attempt or plans	☐	☐	☐	38) Broken bones	☐	☐	☐
06) Sleepwalking	☐	☐	☐	39) Adverse reaction to medication	☐	☐	☐
07) Wear corrective lenses	☐	☐	☐	40) Skin diseases	☐	☐	☐
08) Eye surgery to correct vision	☐	☐	☐	41) Tumor, growth, cyst or cancer	☐	☐	☐
09) Lack vision in either eye	☐	☐	☐	42) Hernia	☐	☐	☐
10) Wear a hearing aid	☐	☐	☐	43) Hemorrhoids or rectal disease	☐	☐	☐
11) Stutter or stammer	☐	☐	☐	44) Frequent or painful urination	☐	☐	☐
12) Wear a brace or back support	☐	☐	☐	45) Bed wetting since age 12	☐	☐	☐
13) Scarlet fever	☐	☐	☐	46) Kidney stone or blood in urine	☐	☐	☐
14) Rheumatic Fever	☐	☐	☐	47) Sugar or albumin in urine	☐	☐	☐
15) Swollen or painful joints	☐	☐	☐	48) Sexually transmitted diseases	☐	☐	☐
16) Frequent or severe headaches	☐	☐	☐	49) Recent gain or loss of weight	☐	☐	☐
17) Dizziness or fainting spells	☐	☐	☐	50) Eating disorder (anorexia, bulimia, etc.)	☐	☐	☐
18) Eye trouble	☐	☐	☐	51) Arthritis, rheumatism or Bursitus	☐	☐	☐
19) Hearing loss	☐	☐	☐	52) Thyroid trouble or goiter	☐	☐	☐
20) Recurrrent ear infections	☐	☐	☐	53) Bone, joint or other deformity	☐	☐	☐
21) Chronic or frequent colds	☐	☐	☐	54) Loss of finger or toe	☐	☐	☐
22) Severe tooth or gum trouble	☐	☐	☐	55) Painful or "trick" shoulder or elbow	☐	☐	☐
23) Sinusitis	☐	☐	☐	56) Recurrent back pain or any back injury	☐	☐	☐
24) Hay fever or allergic rhinitis	☐	☐	☐	57) "Trick" or locked knee	☐	☐	☐
25) Head injury	☐	☐	☐	58) Foot trouble	☐	☐	☐
26) Asthma	☐	☐	☐	59) Nerve Injury	☐	☐	☐
27) Shortness of breath	☐	☐	☐	60) Paralysis (including infantile)	☐	☐	☐
28) Pain or pressure in chest	☐	☐	☐	61) Epilepsy or seizure	☐	☐	☐
29) Chronic cough	☐	☐	☐	62) Car, train, sea or air sickness	☐	☐	☐
30) Palpitation or pounding heart	☐	☐	☐	63) Frequent trouble sleeping	☐	☐	☐
31) Heart trouble	☐	☐	☐	64) Depression or excessive worry	☐	☐	☐
32) High or low blood pressure	☐	☐	☐	65) Loss of memory or amnesia	☐	☐	☐
33) Cramps in your legs	☐	☐	☐	66) Nervous trouble of any sort	☐	☐	☐

Turn Over - Additional Information

Check Each Item	*Yes*	*No*	*???*
67) Periods of unconsciouness	☐	☐	☐
68) Parent / Sibling with diabetes, cancer, stroke or heart disease	☐	☐	☐
69) X-ray or other radiation therapy	☐	☐	☐
70) Chemotherapy	☐	☐	☐
71) Asbestos or toxic chemical exposure	☐	☐	☐
72) Plate, pin or rod in any bone	☐	☐	☐
73) Easy Fatigability	☐	☐	☐
74) Been told to cut down or criticized for alcohol use	☐	☐	☐
75) Used illegal substances	☐	☐	☐
76) Used tobacco	☐	☐	☐

Additional Pre-Exsting Conditions

Check Each Item	*Yes*	*No*
77) 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)	☐	☐
78) Have you ever been treated for a mental condition (if yes, be specific with details)	☐	☐
79) Have you ever been denied life insurance	☐	☐
80) Have you had or been advised to have an operation	☐	☐
81) Have you ever been a patient in any type of hospital	☐	☐
82) Have you consulted or been treated by clinics, physicians, or practitioners within the past 5 years for other than minor illnesses	☐	☐
83) Have you ever been rejected for military service because of physical, mental or other reasons	☐	☐
84) Have you ever been discharged from military service because of physical, mental or other reasons	☐	☐
85) Have you ever received, is there pending, or have you ever applied for pension or compensation for an existing disability	☐	☐
86) Have you ever been diagnosed with a learning disbaility	☐	☐

Check Each Item (females only)	*Yes*	*No*	*???*
87) Treated for a female disorder	☐	☐	☐
88) Change in menstruel pattern	☐	☐	☐

Date of last menstrual period	Date of last PAP Smear	Date of last Mammogram

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

Question #: Explanation:

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

Question #: Explanation:

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Immunizations:

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I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals or clinics mentioned above to furnish my eployer a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information is punishable by fine and/or imprisonment.

Name of Examinee	Signature	Date

Urine Dip
Urinalysis: ______
pH: ______
Alb: ______
Sugar: ______
Ketone: ______
Blood ______
Spec. Gravity: ______

Vision Check

	Without Glasses			With Glasses		
Distant Vision	R20 /	L20 /	B20 /	R20 /	L20 /	B20 /
Near Vision	R14 /	L14 /	B14 /	R14 /	L14 /	B14 /
Horizontal Field of Vision (Degrees)	R	X		L	X	
Color Vision	☐ Pass			☐ Not Pass		
Depth Perception	☐ Normal			☐ Abnormal		

Vitals

Height: ______ Weight: ______ BP: ______

Temp: ______ Respiration: ______ Pulse: ______