

Comprehensive Occupational Health Questionnaire



OCCUPATIONAL HISTORY

Please list all employment you have had starting with the most recent and going backward. List length of time at each job, as well as any known health hazards exposure, i.e. asbestos, noise, etc.

Name: _____

Employer: _____

DOI: _____ **Todays:** _____

MD: _____

LOCATION	APPROX. DATES	EMPLOYER	HOW LONG EMPLOYED	KNOWN HAZARD EXPOSURE

CHECK IF YOU HAVE OR HAVE YOU EVER HAD:

- | | | | | | |
|--|--------------------------|-------------------------------------|--------------------------|-----------------------------------|--------------------------|
| 1) Head Injuries | <input type="checkbox"/> | 19) Sores in mouth | <input type="checkbox"/> | 37) Chronic fatigue | <input type="checkbox"/> |
| 2) Headaches, Dizziness, Fainting | <input type="checkbox"/> | 20) Constipation or diarrhea | <input type="checkbox"/> | 38) Chronic pain syndrome | <input type="checkbox"/> |
| 3) Emotional or Nervous Trouble | <input type="checkbox"/> | 21) Rectal or hemorrhoidal trouble | <input type="checkbox"/> | 39) Exposure to chemicals | <input type="checkbox"/> |
| 4) Convulsions, loss of consciousness | <input type="checkbox"/> | 22) Kidney trouble or stones | <input type="checkbox"/> | 40) Rejection of life insurance | <input type="checkbox"/> |
| 5) Asthma, Hay fever, Sinus trouble | <input type="checkbox"/> | 23) Hernia | <input type="checkbox"/> | 41) Rejection of Military Service | <input type="checkbox"/> |
| 6) Allergies, incl. to medications | <input type="checkbox"/> | 24) Varicose veins | <input type="checkbox"/> | 42) Workman's Comp claim | <input type="checkbox"/> |
| 7) Eye trouble, poor vision | <input type="checkbox"/> | 25) Rheumatism, arthritis, gout | <input type="checkbox"/> | 43) Drug use, cocaine, pot, LSD | <input type="checkbox"/> |
| 8) Ear trouble, poor hearing | <input type="checkbox"/> | 26) Sexually Transmitted Disease | <input type="checkbox"/> | 44) Smoke cigarettes | <input type="checkbox"/> |
| 9) Diabetes | <input type="checkbox"/> | 27) Deformity, amputation | <input type="checkbox"/> | 45) Taking medication | <input type="checkbox"/> |
| 10) TB | <input type="checkbox"/> | 28) Back trouble | <input type="checkbox"/> | Family History | |
| 11) Pneumonia, pleurisy | <input type="checkbox"/> | 29) Operations, injuries, fractures | <input type="checkbox"/> | 46) TB | <input type="checkbox"/> |
| 12) Cough, chest pain | <input type="checkbox"/> | 30) Hospitalization | <input type="checkbox"/> | 47) Diabetes | <input type="checkbox"/> |
| 13) Heart trouble, shortness of breath | <input type="checkbox"/> | 31) Scars, Identifying marks | <input type="checkbox"/> | 48) Heart disease or hypertension | <input type="checkbox"/> |
| 14) Swelling of legs or Ankles | <input type="checkbox"/> | 32) Skin trouble | <input type="checkbox"/> | 49) Epilepsy | <input type="checkbox"/> |
| 15) High or low blood pressure | <input type="checkbox"/> | 33) Recent gain or loss weight | <input type="checkbox"/> | Female Applicants | |
| 16) Stroke, paralysis, weakness | <input type="checkbox"/> | 34) Alcohol use | <input type="checkbox"/> | 50) Womb or ovary trouble | <input type="checkbox"/> |
| 17) Ulcer, indigestion | <input type="checkbox"/> | 35) Cancer | <input type="checkbox"/> | 51) Last Menstrual period? | <input type="checkbox"/> |
| 18) Liver, gall bladder trouble, hepatitis | <input type="checkbox"/> | 36) Persistent fever | <input type="checkbox"/> | 52) X-rays or diagnostics of back | <input type="checkbox"/> |

Please provide the number and a brief explanation of any items checked above:

Please list all medication, prescription, you take regularly, how much and how often.

List all operations, other hospitalizations, and dates.

List all operations, other hospitalizations, and dates.

List all allergic reactions to food, medications, etc., and describe reaction.

How many days a week do you exercise?

THE ABOVE ANSWERS ARE TRUE AND COMPLETE. I AM AWARE THAT ANY FALSIFICATION OF FACT ABOVE MAY BE GROUNDS FOR DISCHARGE. I AUTHORIZE THE RELEASE OF THE RESULTS OF THIS EXAM TO A DULY AUTHORIZED REPRESENTATIVE OF MY EMPLOYER.

Date: _____ Signed: _____