Comprehensive Occupational Health Questionnaire

Work Star
Injury Recovery Center

Name: _____

Employer: _____

DOI: _____ **Todays:** _____

MD: _____

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.

LOCATION	APPROX. DATES	EMPLOYER	HOW LONG EMPLOYED	KNOWN HAZARD EXPOSURE

CHECK IF YOU HAVE OR HAVE YOU EVER HAD:

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

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: _____ Print Form

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