BUSINESS HEALTH SERVICES

COMPREHENSIVE MEDICAL AND OCCUPATIONAL HEALTH HISTORY QUESTIONNAIRE

SITE: ____________________________________

Please answer all questions accurately and completely.

IDENTIFICATION DATE: Fill in the following information. Please PRINT **Today's Date** ____/____/____

____
Name

____
Social Security Number

____
Home Address

____
City State Zip Code

____
Home Telephone (area code)

____/____/____ **Age**____ **Sex** ☐ Male ☐ Female

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Education: ________years in Elementary ______years in High School
________ years in College, Technical, Business, etc.

____
Employer / Department Previously Employed ☐ Yes ☐ No

____
Occupation / Position Applied For

Your Health History: Mark an X in the box next to any of the following illnesses you now have or have ever had.

☐ Anemia
☐ Asthma
☐ Back/Musculoskeletal Problems
☐ Bleeding Tendencies
☐ Bronchitis
☐ Cholesterol/Other Blood Fat Problems
☐ Diabetes
☐ Diverticulosis
☐ Emphysema
☐ Eye Problems
☐ Glaucoma
☐ Hay Fever or Allergies
☐ Headaches (recurrent)
☐ Hearing Trouble
☐ Heart Attack
☐ Hearing Trouble (other)
☐ Hemorrhoids
☐ Hernias
☐ High Blood Pressure
☐ Hives or Rashes
☐ Hospitalizations
☐ Kidney/Bladder trouble
☐ Mental Health Problems
☐ Neuralgia/Neuritis (unexplained pain)
☐ Pneumonia
☐ Rheumatic Fever
☐ Rheumatism/Arthritis
☐ Seizures
☐ Stroke/Mini-Stroke
☐ Substance Abuse
☐ Surgery
☐ Trauma (fall, mva, assault)
☐ Tuberculosis/TB Skin Test
☐ Venereal Disease
☐ Other Chronic Disorders
☐ ______________________

Do you have any phobias? .... ☐ Yes ☐ No
Have you ever been turned down for life insurance, military service or employment because of health problems? .... ☐ Yes ☐ No
Have you ever received a blood transfusion? .... ☐ Yes ☐ No
If ever incarcerated, do you have any reason to believe that you may have acquired an infections/communicable disease?
that needs to be evaluated or possibly treated? .... ☐ Yes ☐ No

Name and Phone # of Personal Physician ____

YOUR EXPOSURE HISTORY: Your continued good health is important to us, your family and to us. With this in mind, we would like you to give us some basic information about your previous work and leisure time activities. Please mark an X in either the Yes or No Box following each of the items listed below.

2

	YES	NO	How Long?
1. Dust			
2. Welding and soldering fumes			
3. Exhaust from engines			
4. Noise			
5. Heat			
6. Aircraft engines			
7.Heavy gunfire			
8. Cold			
9. Unusual stress			

	YES	NO	How Long?
1. Steel mill			
2. Coal mine			
3. Chemical plant			
4. Other heavy Industry			

Notes:

Do you have, or have you ever had a hobby involving:

	YES	NO	How Long?
1. Arsenic			
2. Asbestos			
3. Benzene			
4. Beryllium			
5. Cadmium and its compounds			
6. Carbon Disulfide			
7.Carbon Monoxide			
8. Carbon Tetrachloride			
9. Cement Dust			
10. Chloride			
11. Chrome compounds			
12. Cutting and Soluble Oils			
13. Epoxy resins			
14. Fibrous glass			
15. Fluorides			
16. Hydrogen Sulfide			
17. Lead			
18. Other heavy metals			
19. Microwaves			
20. Pesticides			
21. Phenol			
22. Phosgene			
23. Radioactive substances			
24. Solvents			

Have you ever worked with:

	YES	NO	How Long?
1. Compressed Air (diving)			
2. Engine Exhausts			
3. Loud Noise (shooting, cycling)			
4. Paints, Solvents, Glues			
5. Other Chemicals ___________			
6. Other Exposures			

Notes:

SOCIAL AND PHYSICALACTIVITY: Mark an X in the box *Yes* or *No* in answer to the following questions.
Fill in the blanks where necessary.

I. SMOKING

Do you smoke? .... ☐ Yes ☐ No

☐ Cigarettes ☐ Cigars ☐ Pipe

How many cigarettes a day ______ How many cigars a day ______ Pipe – How often per day ______

Have you ever smoked? .... ☐ Yes ☐ No

How many years? ______ When did you quit? ______

Do you chew tobacco? .... ☐ Yes ☐ No

II. DRUGS AND ALCOHOL

Do you now or have you ever used drugs? .... ☐ Yes ☐ No

Do you drink beer, wine or hard liquor? .... ☐ Yes ☐ No

Average less than 1 drink per day .... ☐ Yes ☐ No

Average 2 or more drinks per day .... ☐ Yes ☐ No

III. PHYSICAL ACTIVITY

How often do you engage in brisk activity that lasts at least 20 minutes?

☐ Rarely ☐ 1-2 times per week ☐ 3 or more times a week

Type: ☐ walking ☐ jogging ☐ biking ☐ other (specify)

☐ swimming ☐ weight lifting ☐ stair machine ☐ ______________________

YOUR CURRENT HEALTH STATUS: Please mark an X in the box next to the following questions.

Question	Yes	No
Do you have any problems with concentration or memory?	☐ Yes	☐ No
Is your weight stable?	☐ Yes	☐ No
If no, have you gained or lost more than 10 pounds in the last three months?	☐ Yes	☐ No
Do you get at least five hours sleep most nights (days)?	☐ Yes	☐ No
Are you generally in a good mood?	☐ Yes	☐ No
During the past two weeks, have you felt down, depressed or hopeless?	☐ Yes	☐ No
During the past two weeks, have you felt little interest or pleasure in doing things?	☐ Yes	☐ No
Do you have any problems with your eyes, ears, nose or throat?	☐ Yes	☐ No
Do you have any problem with your hearing or vision?	☐ Yes	☐ No
Do you have headaches more than once or twice a month?	☐ Yes	☐ No
Have you had any problems with cough, congestion or shortness of breath?	☐ Yes	☐ No
Have you had problems with chest pains?	☐ Yes	☐ No
Do you have dizzy or lightheaded episodes?	☐ Yes	☐ No
Have you ever passed out (fainted)?	☐ Yes	☐ No
Has there been any change in your appetite?	☐ Yes	☐ No
Do you have a problem with nausea, vomiting, diarrhea or constipation?	☐ Yes	☐ No
Do you have any problem with abdominal (belly) pain?	☐ Yes	☐ No
Have you ever had blood or mucous in your stool?	☐ Yes	☐ No
Do you have a problem with passing your stool?	☐ Yes	☐ No
Do you have a problem with passing your urine?	☐ Yes	☐ No
Have you had any problems with your joints or muscles?	☐ Yes	☐ No
Have you ever had neck or back problems?	☐ Yes	☐ No
Have you ever had an injury to your neck, back, extremities or joints?	☐ Yes	☐ No
Have you ever had any broken bones?	☐ Yes	☐ No
Do you have a problem with weakness (loss of strength)?	☐ Yes	☐ No
Do you have numbness or tingling in your extremities?	☐ Yes	☐ No
Have you ever had problems with your breast; pain, lumps, nipple discharge?	☐ Yes	☐ No
Have you ever had any skin problems?	☐ Yes	☐ No
Do you have any unusual lumps or bumps on your skin?	☐ Yes	☐ No
Have you ever been physically or sexually abused?	☐ Yes	☐ No
Have you seen a physician or other healthcare provider more than 2 times in the past 12 months?	☐ Yes	☐ No

FOR WOMEN ONLY:

Question	Yes	No
Are your menstrual periods regular?	☐ Yes	☐ No
Have they changed in the past two years?	☐ Yes	☐ No
Do you regularly have menstrual cramps?	☐ Yes	☐ No
Are they disabling – that is, do they keep you from performing your activities of daily living, going to work	☐ Yes	☐ No

TEST: Mark an X next to those tests which you have had within the last three years.

☐ Chest X-ray	☐ Electrocardiogram/EKG	☐ Hearing Test
☐ Kidney X ray	☐ Electrocardiogram with Exercise/Stress	☐ Back X-ray
☐ GI Series	☐ TB Skin Test	☐ C-T Scan
☐ Colon X-ray	☐ Breathing Test	☐ MRI
☐ Gallbladder Study	☐ Biopsy	☐ Blood Tests
☐ Other _______________	☐ Other_______________	☐ Other _______________

IMMUNIZATIONS: Mark an X next to the immunizations you have had. Enter the year when you were last given the test.
Mark an X after those immunizations to which you know you had a serious reaction.

Year	Immunization	Reaction	Year	Immunization	Reaction
☐ 19___20___	Tetanus/Diphtheria (DTP)	☐	☐ 19___20___	Measles, Mumps, Rubella (MMR)	☐
☐ 19___20___	Polio	☐	☐ 19___20___	Hepatitis A	☐
☐ 19___20___	Influenza	☐	☐ 19___20___	Hepatitis B (Full Series)	☐
☐ 19___20___	Travel Immunizations	☐	☐ 19___20___	Pneumococcal	☐
☐ 19___20___	BCG/Tuberculosis Vaccination	☐	☐ 19___20___	Typhoid	☐
☐ 19___20___	PPD-TB Skin Test	☐			

MEDICINES:

Do you have a history of sensitivity to medicine? ☐ Yes ☐ No

Are you currently taking any medication? ☐ Yes ☐ No

Mark an X in the box next to any medications that you are now taking and/or are now sensitive to.

Now Taking		Sensitive To	Now Taking		Sensitive To
☐	aspirin	☐	☐	Dilantin/anticonvulsants	☐
☐	penicillin	☐	☐	birth control pills	☐
☐	sulfa	☐	☐	diuretics/water pills	☐
☐	codeine	☐	☐	blood thinners/anticoagulants	☐
☐	antibiotics	☐	☐	steroids (e.g.: Cortisone)	☐
☐	sedatives	☐	☐	insulin / diabetic pills	☐
☐	sinus medications	☐	☐	anti-inflammatories (e.g.: Motrin, Advil, Ibuprofen)	☐
☐	laxatives	☐			
☐	cold tablets	☐	☐	pain medication (narcotics)	☐
☐	diet pills	☐	☐	tranquilizers	☐
☐	heart medicines	☐	☐	anti-depressants	☐
☐	high blood pressure	☐	☐	other	☐

PROVIDER COMMENTS:

PLEASE READ THE FOLLOWING CAREFULLY

I hereby certify that the answers and explanations to all preceding questions are true and complete to the best of my knowledge. I realize that any falsification or concealment of facts may result in termination of my employment.

I agree to have a pre-placement or initial examination, tuberculin skin test, blood and urine test, chest x-ray and other tests deemed necessary prior to employment and at subsequent intervals to be determined by the BEHSI staff.

I hereby consent to allow the performance of breath and/or body fluid testing for alcohol and/or drugs. Your blood and/or urine will not be used for AIDS testing.

I understand that all information given in this questionnaire is retained in my confidential medical record. I understand that only information related to my ability to perform the essential functions of my position will be released to my employer.

______________________________ ______________________________

Signature Date Provider Signature Date