

MEDICAL HISTORY QUESTIONNAIRE



MUNSON HEALTHCARE
Occupational Health
& Medicine

Name _____ Date _____

Company _____ Purpose: Post Offer Other _____

Please Answer The Following Questions

Have you had or do you now have any of the following:

Yes No

- Allergies, asthma, hay fever
- Head injury
- Hearing loss or ringing of ears
- Vision loss / Eye problems
- Neck pain
- Shortness of breath / Lung problems
- Persistent cough
- Chest Pain / Pressure
- Heart problems, high blood pressure
- Anemia
- Persistent abdominal pain or stomach problems
- Ulcers / Indigestion
- Hemorrhoids / Blood in stool
- Hepatitis or liver disease
- Headaches or seizures / convulsions

Yes No

- Fainting spells or dizziness
- Diabetes (sugar)
- Cancer, tumor
- Back pain or back injury
- Arthritis, joint problems, rheumatism
- Wrist or hand problems, carpal tunnel
- Fractures / Broken bones
- Skin disease / problems
- Nervous breakdown / psychiatric condition
- Varicose veins
- Hernia
- Kidney or urinary trouble

WOMEN ONLY

- Any disease of femal organs
- Breast disease
- Are you pregnant
- Date of last period _____

Explain yes answers _____

Any other medical problems not listed? _____

Surgeries: _____ Medication allergy: _____

_____ List medications: _____

Prior Employment: 1. _____ How Long? _____
 2. _____ How Long? _____
 3. _____ How Long? _____

Yes No

- Have you ever been rejected for employment, armed forces or insurance?
- Have you ever received workmen's compensation benefits or disability?
- Have you ever had radiation exposure for medical treatment or from radioactive material?
- Have you worked with asbestos?
- Have you worked in a foundry, mine or chemical industry?
- Do you smoke? If yes, how much (packs a day)? _____ How long have you smoked? _____
- Do you drink alcohol? If yes, how much? _____ a day _____ a week
- Do you use other drugs such as marijuana, cocaine, etc.?
- Have you ever been treated for drug or alcohol abuse?

I certify that the above answers are complete and true to the best of my knowledge and ability and I understand that falsification of this information may result in discharge. Please accept this as authorization to release to my (potential) employer all information pertaining to my physical exam. My health risks and/or significant findings have been discussed with me. I have been advised that the pre-placement health evaluation is not a complete health assessment and is not intended to take the place of private medical attention.

Signature of Witness _____

Signature _____

Date _____



PHYSICAL EXAM

Reason for Exam: Post offer/pre-placement Return to work Exit Other _____

Name _____ Sex _____ DOB _____ Age _____

Item Examined	Blood Pressure		Pulse Rate	After Exercise	Item Examined	Normal	Abnormal	Not Examined
	Sitting	Standing						
1. Head, neck, face, scalp					10. Genitalia/Hernia			
2. Ears: general					11. Anus/Rectal			
3. Nose: sinuses					12. Upper extremities			
4. Eyes: general motility, pupils					13. Hands			
5. Mouth, gums, teeth					14. Lower extremities			
6. Pharynx, tonsils					15. Spine/Back			
7. Cardiac					16. Skin			
8. Lungs					17. Neurologic			
9. Abdomen					18. Psychiatric			

Comments on physical exam: _____

19. Visual Acuity:

	O.D.	O.S.	O.U.
Corrected -			
Uncorrected -			

Peripheral vision Rt _____ Lt _____
 Color Vision: _____ of _____
 Depth Perception _____ of _____

22. Audiometric test:
 _____ (See report)

23. Pulmonary Function test:
 _____ (See report)

20. Urine (See report) SpGr _____
 Blood _____ Protein _____ Glucose _____

24. Special Tests:
 ECG: Abnormal Normal See report
 Hematology: Normal See report
 Blood Chemistry: Normal See report
 Intra Ocular Tension: Right _____ Left _____
 Drug Screen: Negative Positive - see report
 Urine Micro: Casts _____ See report
 Leucocytes _____ Erythrocytes _____

21. X-Ray:
 Chest Abnormal Normal
 Other Abnormal Normal
 See report

25. PPD/TB _____ Mantoux _____
 No Reaction MM of induration: _____

Comments/Recommendations: _____

- Circle if Applicable:
1. Recommend use of hearing protection
 2. Discontinue use of tobacco products
 3. Follow-up with private physician for general health maintenance
 4. Discuss with private physician weight loss program/testicular self exam/reducing cholesterol/breast self exam/regular exercise program
 5. See your private physician to discuss your abnormal findings on examination today.

Part A. Section 2 Continued:

3. Have you ever had any of the following pulmonary or lung problems?

- | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Asbestosis | <input type="checkbox"/> | <input type="checkbox"/> | B. Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Chronic bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | D. Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | E. Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | F. Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | G. Silicosis | <input type="checkbox"/> | <input type="checkbox"/> | H. Pneumothorax (collapsed lung) |
| <input type="checkbox"/> | <input type="checkbox"/> | I. Lung cancer | <input type="checkbox"/> | <input type="checkbox"/> | J. Broken ribs |
| <input type="checkbox"/> | <input type="checkbox"/> | K. Any chest injuries or surgeries | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | L. Any other lung problem that you've been told about: _____ | | | |

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Shortness of breath when walking fast on level ground or walking up a slight hill or incline |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Shortness of breath when walking with other people at an ordinary pace on level ground |
| <input type="checkbox"/> | <input type="checkbox"/> | D. Have to stop for breath when walking at your own pace on level ground |
| <input type="checkbox"/> | <input type="checkbox"/> | E. Shortness of breath when washing or dressing yourself or that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | F. Coughing that produces phlegm (thick sputum) |
| <input type="checkbox"/> | <input type="checkbox"/> | G. Coughing that wakes you early in the morning |
| <input type="checkbox"/> | <input type="checkbox"/> | H. Coughing that occurs mostly when you are lying down |
| <input type="checkbox"/> | <input type="checkbox"/> | I. Wheezing at work or away from work |
| <input type="checkbox"/> | <input type="checkbox"/> | J. Chest pain when you breathe deeply |
| <input type="checkbox"/> | <input type="checkbox"/> | K. Any other symptoms that you think may be related to lung problems |

5. Have you ever had any of the following cardiovascular or heart problems?

- | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | B. Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Angina | <input type="checkbox"/> | <input type="checkbox"/> | D. Heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | E. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | F. Heart arrhythmia (beating irregularly) |
| <input type="checkbox"/> | <input type="checkbox"/> | G. Swelling in your legs or feet (not caused by walking) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | H. Any other heart problem that you've been told about: _____ | | | |

6. Have you ever had any of the following cardiovascular or heart symptoms?

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Frequent pain or tightness in your chest |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Pain or tightness in your chest during physical activity or that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | D. In the past two years, have you noticed your heart skipping or missing a beat |
| <input type="checkbox"/> | <input type="checkbox"/> | E. Heartburn or indigestion that is not related to eating |
| <input type="checkbox"/> | <input type="checkbox"/> | F. Any other symptoms that you think may be related to heart or circulation problems: _____ |

7. Do you currently take medication for any of the following problems? If yes, please list medications.

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Breathing or lung problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Heart trouble _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Blood pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | D. Seizures (fits) _____ |

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, mark no space and go to question 9).

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Eye irritation |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Skin allergies or rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | D. General weakness or fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | E. Any other problem that interferes with your use of a respirator |

9. Would you like to talk to the health care professional who will review your answers to this questionnaire?

The following questions (10-15) must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

Yes **No**
10. Have you ever lost vision in either eye (temporarily or permanently)?

11. Do you currently have any of the following vision problems?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	A. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	B. Wear glasses
<input type="checkbox"/>	<input type="checkbox"/>	C. Color blind	<input type="checkbox"/>	<input type="checkbox"/>	D. Any other eye or vision problem

12. Have you ever had an injury to your ears, including a broken ear drum?

13. Do you currently have any of the following hearing problems?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	A. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	B. Wear a hearing aid
<input type="checkbox"/>	<input type="checkbox"/>	C. Any other hearing or ear problem			

14. Have you ever had a back injury?

15. Do you currently have any of the following musculoskeletal problems?

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	A. Weakness in any of your arms, hands, legs, or feet
<input type="checkbox"/>	<input type="checkbox"/>	B. Back pain
<input type="checkbox"/>	<input type="checkbox"/>	C. Difficulty fully moving your arms and legs
<input type="checkbox"/>	<input type="checkbox"/>	D. Pain or stiffness when you lean forward or backward at the waist
<input type="checkbox"/>	<input type="checkbox"/>	E. Difficulty fully moving your head up or down or side-to-side
<input type="checkbox"/>	<input type="checkbox"/>	F. Difficulty bending at your knees or squatting to the ground
<input type="checkbox"/>	<input type="checkbox"/>	G. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.
<input type="checkbox"/>	<input type="checkbox"/>	H. Any other muscle or skeletal problem that interferes with using a respirator: _____

PART B

Section 1. Please answer the following questions by marking the appropriate box or filling in the space.

Yes **No**
1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?
If yes, name the chemicals: _____

2. Have you ever worked with any of the materials, or under any of the conditions, listed below:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	A. Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	B. Silica (e.g., in sandblasting)
<input type="checkbox"/>	<input type="checkbox"/>	C. Tin	<input type="checkbox"/>	<input type="checkbox"/>	D. Beryllium
<input type="checkbox"/>	<input type="checkbox"/>	E. Aluminum	<input type="checkbox"/>	<input type="checkbox"/>	F. Coal (for example, mining)
<input type="checkbox"/>	<input type="checkbox"/>	G. Iron	<input type="checkbox"/>	<input type="checkbox"/>	H. Dusty environments
<input type="checkbox"/>	<input type="checkbox"/>	I. Tungsten/cobalt (e.g., grinding or welding this material)			
<input type="checkbox"/>	<input type="checkbox"/>	J. Any other hazardous exposures. If yes, describe these exposures: _____			

3. List any second jobs or side business you have: _____

Yes **No**
4. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?
If yes, name the medications: _____

PART B Section 1 Continued

5. How often are you expected to use the respirator(s)? Mark Yes or No for all answers that apply to you.

Yes No

- A. Escape only (no rescue)
C. Less than 5 hours per week
E. 2 to 4 hours per day

Yes No

- B. Emergency rescue only
D. Less than 2 hours per day
F. Over 4 hours per day

6. During the period you are using the respirator(s), is your work effort:

Yes No

- A. Light (less than 200 kcal per hour)

If yes, how long does this period last during the average shift: _____ hrs _____ mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs) or controlling machines.

- B. Moderate (200 to 350 kcal per hour)

If yes, how long does this period last during the average shift: _____ hrs _____ mins.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs) at trunk level; walking on a level surface about 2 mph or down a 5 degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs) on a level surface.

- C. Heavy (above 350 kcal per hour)

If yes, how long does this period last during the average shift: _____ hrs _____ mins.

Examples of heavy work are lifting a heavy load (about 50 lbs) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8 degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

Yes No

7.

Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?

If yes, describe this protective clothing and/or equipment: _____

8.

Will you be working under hot conditions (temperature exceeding 77° F)?

9.

Will you be working under humid conditions?

10. Describe the work you'll be doing while you're using your respirator(s): _____

Patient Signature: _____ Date: _____

Reviewers Signature: _____ Date: _____