

Benzene Surveillance: MEDICAL QUESTIONNAIRE

CONFIDENTIAL

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Name: _____

Birth-date: _____

Today's Date: _____

1. Have you ever been exposed to **Benzene** or other **Hematological Toxins** at work? ☐ yes ☐ no
If yes, please explain: _____
2. Any **Family History** of blood diseases, blood disorders, or blood cell cancers? ☐ yes ☐ no
If yes, please explain: _____
3. A **Personal History** of:
 - a. Blood disorders including genetic hemoglobin abnormalities, bleeding abnormalities, and/or abnormal function of any formed blood elements? ☐ yes ☐ no
 - b. Kidney or Liver dysfunction? ☐ yes ☐ no
 - c. Exposure to Ionizing Radiation? ☐ yes ☐ no
 - d. Past exposure to Marrow Toxins? ☐ yes ☐ noIf yes, please explain: _____
4. Have you experienced any of the following symptoms since last year (check all that apply)?:

<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Persistent fatigue, weakness
<input type="checkbox"/> Frequent, prolonged or severe infections	<input type="checkbox"/> Losing weight without trying
<input type="checkbox"/> Swollen lymph nodes, enlarged liver or spleen	<input type="checkbox"/> Easy bleeding or bruising
<input type="checkbox"/> Tiny red spots in your skin (petechiae)	<input type="checkbox"/> Excessive sweating, especially at night
<input type="checkbox"/> Bone pain or tenderness	<input type="checkbox"/> Shortness of breath with exertion
<input type="checkbox"/> Rapid or irregular heart rate	<input type="checkbox"/> Pale skin
<input type="checkbox"/> Unexplained or easy bruising	<input type="checkbox"/> Recurrent nosebleeds and bleeding gums
<input type="checkbox"/> Prolonged bleeding from cuts	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headache

Please explain those checked: _____
5. Any past or present routine **Medication** use? ☐ yes ☐ no
If yes, please list those medications: _____

I certify that the information I have provided in the above medical history is complete, true, and accurate to the best of my knowledge. I understand that falsification or omission of any of the preceding information would misinform the medical practitioner of my medical history and potentially result in harm to myself, for which I would not hold the medical practitioner responsible. Additionally, I understand the care and information I received today is not a substitute for the care and information that I receive from my primary care physician. I agree that the Health Examination requested by the above-named company is made with my consent and that the examination, test(s), and/or result(s) may be released to the above-named company and/or its representatives.

Patient Signature

Printed

Date/Time

Remarks by OMC staff:

Provider Signature / Date

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