Benzene Surveillance: MEDICAL QUESTIONNAIRE

CONFIDENTIAL

Washington Health System Occupational Medicine • 95 Leonard Avenue, Bldg. 1, Suite 401, Washington, Pa 15301• WHS Greene Plaza • 220 Greene Plaza • Waynesburg, PA 15370 • Phone: 724-223-352, Fax: 724-229-2401

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 ☐ no

   If yes, please explain: ____
   ____
   ____.

4. Have you experienced any of the following symptoms since last year (check all that apply)?:
   - ☐ Fever or chills
   - ☐ Frequent, prolonged or severe infections
   - ☐ Swollen lymph nodes, enlarged liver or spleen
   - ☐ Tiny red spots in your skin (petechiae)
   - ☐ Bone pain or tenderness
   - ☐ Rapid or irregular heart rate
   - ☐ Unexplained or easy bruising
   - ☐ Prolonged bleeding from cuts
   - ☐ Dizziness
   - ☐ Persistent fatigue, weakness
   - ☐ Losing weight without trying
   - ☐ Easy bleeding or bruising
   - ☐ Excessive sweating, especially at night
   - ☐ Shortness of breath with exertion
   - ☐ Pale skin
   - ☐ Recurrent nosebleeds and bleeding gums
   - ☐ Skin rash
   - ☐ 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:

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Provider Signature / Date