WASHINGTON HEALTH SYSTEM
Occupational Medicine

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Lead Surveillance: MEDICAL QUESTIONNAIRE

CONFIDENTIAL

Name: _____ Birth Date: _____ Today's Date: _____

1. Please list your **prior jobs** in Reverse Chronology:

Job Title	Employer	Dates of Employment

2. Have you ever been exposed to **Lead** at work or home? ……..☐ Yes ☐ No
   If yes, please explain: _____
   _____
3. Do you **smoke** or use **tobacco** products regularly? ……...☐ Yes ☐ No
4. Do you practice good hygiene habits especially hand washing before food consumption and bathing after work?.....☐ Yes ☐ No
5. Please list your past/current **Medical Conditions**:
   _____
   _____
6. Please list any past or present routine **Medication** use:
   _____
   _____
7. Due you have a **Personal History** of:
   a. Stomach, Intestinal, or other gastrointestinal problems? ☐ Yes ☐ No
   b. Kidney or Bladder problems? ☐ Yes ☐ No
   c. Bleeding problems or blood illnesses? ☐ Yes ☐ No
   d. Heart or vascular problems? ☐ Yes ☐ No
   e. Reproductive issues or sterility? ☐ Yes ☐ No
   f. Nerve problems, paralysis, numbness, weakness, or other neurological issues? ☐ Yes ☐ No

   If yes, please explain: _____
   _____
   _____

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

PLEASE DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Remarks by OMC staff:

_____
_____

_____ _____ _____
Reviewer's Signature Printed Date/Time