WASHINGTON HEALTH SYSTEM
Occupational Medicine

95 Leonard Ave. • Bldg.1 • Suite 401• Washington, PA 15301 • WHS Greene Plaza • 220 Greene Plaza • Waynesburg, PA 15370 • P: 724-223-3528 F: 724-229-2401

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