Hexavalent Chromium Surveillance: MEDICAL QUESTIONNAIRE

CONFIDENTIAL

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

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

1. Have you ever been, are you currently, or do you anticipate to be exposed to **Chomium 6** at work or home?
□ yes □ no
If yes, please explain: _____
_____
_____.

2. A **Personal History** of:

a.	Lung or breathing problems?	□ yes □ no
b.	Respiratory system dysfunction?	□ yes □ no
c.	Asthma, Bronchitis?	□ yes □ no
d.	Lung Cancer?	□ yes □ no
e.	Skin irritation or rashes?	□ yes □ no
f.	Skin ulceration?	□ yes □ no
g.	Nasal septum perforation?	□ yes □ no

If yes, please explain: _____
_____
_____.

3. Smoking status? □ current □ past □ not applicable

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:
_____
_____
_____
_____.

_____
Provider Signature