

MEDICAL AND OCCUPATIONAL HISTORY FORM (CONFIDENTIAL)

Name: _____ DOB: _____ Today's date: _____ Job Title: _____

1. List any past or present **Medication** use; how long you've been using current Medication; and do you have any side effects. If you take no medications, check this box ☐ :

2. (Medical History Section) Describe any **Work Related** injuries or health issues; if none, check this box ☐ :

(Medical History Section) **Do you have any HISTORY of the following?**

Condition	YES	Condition	YES	Condition	YES
Hernia	<input type="checkbox"/>	Carpal tunnel/tendonitis	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Back Injury	<input type="checkbox"/>	Seizures/epilepsy	<input type="checkbox"/>	Lung Disease/Asthma	<input type="checkbox"/>
Current Back Issues	<input type="checkbox"/>	Loss of consciousness	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>
Neck Injury	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>
Current Neck Issues	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>
Amputation	<input type="checkbox"/>	General Cardiovascular issues	<input type="checkbox"/>	Kidney/bladder issues	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Heart attack/issues	<input type="checkbox"/>	Female Conditions	<input type="checkbox"/>
Joint injuries/issues	<input type="checkbox"/>	Paralysis/stroke	<input type="checkbox"/>	Blood disorders/Anemia	<input type="checkbox"/>
Broken/fractured bones	<input type="checkbox"/>	Ear/Nose/Throat issues	<input type="checkbox"/>	Tumor/cancer/cyst	<input type="checkbox"/>
Hand/finger injuries	<input type="checkbox"/>	General Pulmonary issues	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Foot/toe injuries	<input type="checkbox"/>	Mental/nervous conditions	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Numbness/tingling	<input type="checkbox"/>	Hearing/ear problems	<input type="checkbox"/>	Undergone physical or occupational therapy	<input type="checkbox"/>
General Neurologic issues	<input type="checkbox"/>	Eye problems (not glasses)	<input type="checkbox"/>	Ever received Workers' Compensation benefits?	<input type="checkbox"/>

Please explain yes answers:

We will be performing a urine dip to check for blood, etc. Are you currently having your menstrual cycle? ☐ yes ☐ no

Other Illness/Issue not stated:

Work Restrictions, currently? ☐ Yes (please specify), ☐ No:

Corrections Officers only:

Have you been exposed to pepper spray before? ☐ yes ☐ no

If yes, any adverse effect? ☐ yes ☐ no Explain: _____

3. List any **Allergies/Intolerances**; if none, check this box ☐ : _____

4. List any past **Surgeries**; if none, check this box ☐ : _____

5. List any past **Hospital Admissions**, dates, why you were there; if none, check this box ☐ : _____

6. **Social History:**

	YES	NO	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If so, frequency and amount:
Smoke (now or in the past)?	<input type="checkbox"/>	<input type="checkbox"/>	If so, frequency and amount:
Take habit forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what are they:
Treated for drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when did you complete treatment?
Treated for alcoholism?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when did you complete treatment?

I certify that I have answered these questions truthfully and to the best of my knowledge.

Patient Signature

Printed Name

Date/Time

Provider Signature/Printed

Date