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

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?	☐	☐	If so, frequency and amount:
Smoke (now or in the past)?	☐	☐	If so, frequency and amount:
Take habit forming drugs?	☐	☐	If yes, what are they:
Treated for drug addiction?	☐	☐	If yes, when did you complete treatment?
Treated for alcoholism?	☐	☐	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