Your Hospital's Logo Here

Medical History Form

Occupational Health Services
Street Address
City, State Zip
(202) 555 - 1212

For POSITION:		DEPARTMENT:				
LAST NAME:	FIRST NAME:	MI:	SEX:	RACE:	AGE:	DATE OF BIRTH:
STREET ADDRESS: (CITY) (STATE) (ZIP)					HOME TEL: - -	
SOC SEC #: - -	MARITAL STATUS:	# OF CHILDREN:		FAMILY PHYSICIAN:		
IN CASE OF EMERGENCY, PLEASE NOTIFY:	NAME:				HOME TEL: - -	
	ADDRESS:				WORK TEL: - -	

FAMILY HISTORY: Have any of your relatives had, or do they now have ...

	Y	N		Y	N		Y	N
ALLERGIES	☐	☐	EPILEPSY / SEIZURES	☐	☐	MENTAL ILLNESS (Depression, Anxiety)	☐	☐
CANCER	☐	☐	HEART TROUBLE	☐	☐			
DIABETES	☐	☐	HIGH BLOOD PRESSURE	☐	☐	TUBERCULOSIS	☐	☐

SELF HISTORY: Do you now -or- have you ever had … (explain "YES" answers below)

	Y	N		Y	N		Y	N
ANEMIA	☐	☐	FRACTURES	☐	☐	MEASLES	☐	☐
ANXIETY	☐	☐	FREQ. DIFFICULTY SLEEPING	☐	☐	MENTAL ILLNESS / PSYCHIATRIC Tx:	☐	☐
ARTHRITIS	☐	☐	FREQ. HEADACHES	☐	☐	MUMPS	☐	☐
ASTHMA	☐	☐	HIGH BLOOD PRESSURE	☐	☐	NERVOUS TROUBLE	☐	☐
CANCER	☐	☐	HEAD INJURY	☐	☐	NUMBNESS / TINGLING	☐	☐
CHICKENPOX	☐	☐	HEART TROUBLE / MURMUR	☐	☐	PAIN	☐	☐
DERMATITIS / SKIN TROUBLE	☐	☐	HEPATITIS / LIVER TROUBLE	☐	☐	PNEUMONIA / PLEURISY	☐	☐
DIABETES	☐	☐	HERNIA / RUPTURE	☐	☐	RHEUMATIC / SCARLET FEVER	☐	☐
DIZZY SPELLS / BLACKOUTS	☐	☐	JOINT ACHES	☐	☐	STROKE	☐	☐
EPILEPSY / SEIZURES	☐	☐	KIDNEY TROUBLE	☐	☐	THYROID DISORDER	☐	☐
						VISION PROBLEM (incl. Glasses)	☐	☐
						WEAK IMMUNE SYSTEM	☐	☐

EXPLANATION: _____

ALLERGY HISTORY:

	Y	N	EXPLANATION		Y	N	EXPLANATION
PENICILLIN	☐	☐		LATEX	☐	☐	
SULFA	☐	☐		EGGS	☐	☐	
NEOMYCIN	☐	☐		YEAST	☐	☐	
TETANUS ANTI-TOXIN	☐	☐		POLLEN, GRASSES, DUST	☐	☐	

OTHER DRUGS: _____ (LIST)

OTHER FOODS / AGENTS: _____ (LIST)

IMMUNIZATION HISTORY:

	IMMUNIZATION DATE	TITER DATE		IMMUNIZATION DATE	TITER DATE
HEPATITIS B			RUBELLA		
MUMPS			VARICELLA		
MEASLES (RUBEOLA)			TETANUS / DIPHTHERIA		

WOMEN ONLY:

LAST MENSTRUAL PERIOD: _____ ARE YOU PREGNANT? ☐ **Y** ☐ **N** EXPECTED DUE DATE: _____

TUBERCULIN STATUS:

DATE OF **LAST PPD** (TB Skin Test): _____ RESULT: _____

DATE OF **LAST CHEST X-RAY** (for Positive PPD): _____ RESULT: _____

HAVE YOU EVER HAD THE BCG VACCINE?: ☐ **Y** ☐ **N**

OCCUPATIONAL HISTORY:

WHAT IS YOUR USUAL WORK OCCUPATION? HOW LONG HAVE YOU BEEN EMPLOYED IN THIS OCCUPATION?

WHAT WAS YOUR PREVIOUS OCCUPATION?

DESCRIBE ANY WORK-RELATED INJURIES YOU'VE HAD, AND DATE OF INJURY(IES):

HAVE YOU EVER WORKED WITH OR LIVED NEAR SUSPECTED CARCINOGENIC SUBSTANCES (Asbestos, Coal Dust, Mining, ETO Formalin, etc.)? **IF "YES", EXPLAIN:**

HAVE YOU EVER HAD A BLOODBORNE PATHOGEN EXPOSURE? **IF "YES", EXPLAIN:**

WERE YOU TREATED WITH ANY PROPHYLACTIC MEDICATION FOR A BLOODBORNE PATHOGEN EXPOSURE? **IF "YES", EXPLAIN:**

HAVE YOU EVER RECEIVED A DISABILITY RATING FROM THE VETERANS ADMINISTRATION, THE SOCIAL SECURITY ADMINISTRATION, THE WORKERS COMPENSATION COMMISSION, OR A FORMER EMPLOYER FOR A CONDITION WHICH MIGHT AFFECT YOUR PERFORMANCE OF THE WORK INVOLVED IN THE POSITION FOR WHICH YOU ARE APPLYING? **IF "YES", EXPLAIN:**

HAVE YOU OR ARE YOU NOW RECEIVING ANY FORM OF DISABILITY BENEFIT PAYMENT FOR A CONDITION THAT MIGHT AFFECT YOUR PERFORMANCE OF WORK INVOLVED IN THE POSITION FOR WHICH YOU ARE NOW APPLYING? **IF "YES", EXPLAIN:**

DO YOU CURRENTLY HAVE A DISABILITY CLAIM PENDING FOR A CONDITION THAT MIGHT AFFECT YOUR PERFORMANCE OF THE WORK INVOLVED IN THE POSITION FOR WHICH YOU ARE NOW APPLYING? **IF "YES", EXPLAIN:**

GENERAL HEALTH:

DESCRIBE ANY KNEE AND/OR ANKLE INJURY OR PROBLEM / DATE?

DESCRIBE ANY SHOULDER INJURY OR PROBLEMS / DATE?

DESCRIBE ANY NECK INJURY OR PROBLEMS / DATE?

DESCRIBE ANY BACK INJURY OR PROBLEMS / DATE?

DESCRIBE ANY MEDICAL ATTENTION RECEIVED IN THE PAST YEAR: (Please be specific)

ARE YOU CURRENTLY TAKING ANY **PRESCRIPTION** MEDICATIONS, ANY **OVER-THE-COUNTER** MEDICATIONS, ANY **FOOD SUPPLEMENTS** OR ANY **HERBAL SUPPLEMENTS**? **IF "YES", LIST:**

DO YOU SMOKE?	IF "YES", DESCRIBE FREQUENCY BELOW:	DO YOU DRINK ALCOHOL?	IF "YES", DESCRIBE FREQUENCY BELOW:
☐ YES ☐ NO	_____ Packs per __DAY __WEEK	☐ YES ☐ NO	_____ Times / Day _____ Drinks / Wk

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS? **IF "YES", EXPLAIN:**

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? **IF "YES", WHEN (Date) & EXPLAIN:**

HAVE YOU EVER HAD AN OPERATION? **IF "YES", WHEN (Date) & EXPLAIN:**

I agree to take a pre-employment and annual health examination consisting of such tests, procedures, and examinations as deemed necessary when requested by hospital authorities. These tests will be performed by qualified personnel designated by the hospital, or by a private physician at my own expense, and the results will be furnished to the hospital. Also, I agree to take blood and urine tests to determine the content of alcohol and/or drugs in my body when requested to do so by the authorities of the Hospital. I understand that failure to comply with these requests could result in disciplinary action up to and including discharge. I certify that the answers to the above questions are true and understand that any misstatement of fact or withholding health information on this Medical History Form can result in my discharge from hospital employment. In accord with Federal Regulations, information gained by Occupational Health Services concerning your protected health information and/or health status may be released to your employer.

SIGNED: _____ **DATE:** _____

SIGNATURE OF INDIVIDUAL