Quad City & Clinton Occupational Health

Health History

Name: _____ **Company:** _____ **Date:** _____

IMMUNIZATIONS

Date of last tetanus: _____

Hepatitis vaccinations:

Dates - # 1 _____
2 _____
3 _____

Have you had Chicken Pox? ____Y _____N

Last TB test: _____

Check Appropriate response

EYES

Yes No

___ ___ Do you wear glasses/contacts?
For: Reading _____
Distance _____
___ ___ Are you color blind?
___ ___ Do you have blurred vision?
___ ___ Previous eye injury
___ ___ Previous eye surgery

EAR, NOSE and THROAT

___ ___ Do you have nose bleeds?
___ ___ Do you have hoarseness?
___ ___ Previous ear surgery
___ ___ Do you have hearing loss?
___ ___ Do you have ear problems?

CARDIO-PULMONARY

Have any history of the following:

___ Asthma ___ Emphysema
___ Lung Surgery ___ Tuberculosis (TB)

Do you:

___ ___ Have shortness of breath or
___ ___ Wheezing
___ ___ Cough up blood
___ ___ Have recurrent bronchitis
___ ___ Smoke ____ Packs per day
____ Number of years

___ ___ Have high blood pressure
___ ___ Have a heart murmur
___ ___ Have chest pain/palpitations
___ ___ Have swollen legs or ankles
___ ___ Have fainting or dizzy spells
___ ___ Have varicose veins
___ ___ Have you ever had a
___ ___ Heart attack Date:_____
___ ___ Previous stress test/cardiac cath
Sleep Apnea: ___ Yes ___ No
___ ___ Stroke
___ ___ Difficulty with urination
___ ___ Blood in urine
___ ___ Bladder problems
___ ___ Kidney- Infection ____
Stones ____
Injury ____
___ ___ Surgery: _____

GASTROINTESTINAL

Yes No

Have you had any of the following:

___ ___ Heartburn or ulcers
___ ___ Blood in vomit
___ ___ Black stools
___ ___ Rectal bleeding/pain
___ ___ Hemorrhoids
___ ___ Difficulty swallowing
___ ___ Hernia(s)
___ ___ Liver problems
___ ___ Hepatitis
___ ___ Jaundice
___ ___ Gallbladder problems
___ ___ Surgery

MUSCULOSKELETAL

Have you had any of the following:

___ ___ Neck injury or surgery
___ ___ Back injury or surgery
___ ___ Shoulder injury or surgery
___ ___ Elbow injury or surgery
___ ___ Hand injury or surgery
___ ___ Hand or arm numbness or pain
___ ___ Carpal tunnel
___ ___ Awoke from sleep by hand pain
___ ___ Decreased grip strength
___ ___ Tendonitis
___ ___ Swollen joints
___ ___ Hip injury or surgery
___ ___ Knee injury or surgery
___ ___ Ankle injury or surgery
___ ___ Feet injury or surgery
___ ___ Fractures/Broken Bones

NEUROLOGICAL

Have you had any of the following:

___ ___ Head injury or surgery
___ ___ Frequent headaches
___ ___ Seizures or convulsions

MOOD

Have you ever had:

___ ___ Bipolar d/o (Manic Depression)
___ ___ Anxiety or Depression
___ ___ Nervous breakdown
___ ___ Post Traumatic Stress Disorder
___ ___ Schizophrenia
___ ___ Psychiatric hospitalizations

ALLERGIES

Have you ever had:

Reactions to –

____ Medications ____ Chemicals
____ Fruits/Nuts ____ Rubber
____ Adhesives ____ Plants

Any of the following-

____ Hives/Rashes ____ Tearing
____ Runny nose ____ Wheezing
____ Sneezing

Are you _____Rt. Or _____ Lt. handed?

MEDICAL PROBLEMS

Yes No

Have you ever had:

___ ___ Anemia
___ ___ Cancer- Type _____
___ ___ Diabetes
___ ___ Fatigue
___ ___ Goiter/Thyroid problems

CURRENT MEDS

_____ _____
_____ _____
_____ _____

EXPOSURE HISTORY

Have you ever been exposed to the following in the past:

___ Acids	___ Chromates	___ Pesticides
___ Alkalis	___ Coal	___ Radiation
___ Ammonia	___ Fiberglass	___ Rock dust
___ Arsenic	___ Isocyanates	___ Silica
___ Asbestos	___ Lead	___ Solvents
___ Beryllium	___ Manganese	___ Vibration
___ Cadmium	___ Mercury	___ Welding
___ Chloroform	___ Nickel	___ X-rays

WORK HISTORY

List your previous jobs. Most recent first.

_____
_____
_____
_____

I understand this physical examination is for job placement purposes and is not a complete physical exam. I understand that I should see my personal physician if I wish to undergo a more extensive physical to assess my complete medical status.

The information I have provided above is correct to the best of my knowledge.

Signature: _____

Date: _____

Quad City & Clinton Occupational Health

Name:

Health History

NURSE

HT:_____ WT: _____ BP: / PULSE:_____ UA DIP: SG:_____ PRO: _____SUG:_____ BLD: _____

VISION: FAR WITH 20/____ OD(R), 20/____OS(L), 20/____OU(BOTH) WITHOUT 20/____(R), 20/____(L), 20/____OU(BOTH)

NEAR ____ OD ____ OS ____ OU ____ OD ____ OS ____ OU

GRIP R____ L ____ COLOR R/G/Y____ ISHIHARA____ Peripheral Vision ____OD ____ OS ____ OU

(Must Do) HEARING: (Whispered) AD AS AU

PHYSICIAN

HEENT

N	ABN	N/A	
_____	_____	_____	Head
_____	_____	_____	Ears
_____	_____	_____	EOMI
_____	_____	_____	Fundi
_____	_____	_____	Eyes
_____	_____	_____	Nose
_____	_____	_____	Throat
_____	_____	_____	Thyroid
_____	_____	_____	Lymph Nodes
_____	_____	_____	Bruits

Heart/Lung

_____	_____	_____	Heart
_____	_____	_____	Description
_____	_____	_____	Lungs

GastroIntestinal

_____	_____	_____	Abd
_____	_____	_____	Description
_____	_____	_____	Scars
_____	_____	_____	Description
_____	_____	_____	Bowel Sounds
_____	_____	_____	Bruits

G U System

Males

_____	_____	_____	**Gen**
_____	_____	_____	**Hernia**

(Rest of exam on request only)

_____	_____	_____	Rectal
_____	_____	_____	Guaiac
_____	_____	_____	Prostate

Females (On request only)

_____	_____	_____	Gen
_____	_____	_____	BUS

Musculoskeletal

N	ABN	N/A	
Neck			
_____	_____	_____	ROM
_____	_____	_____	Scans/Def.

R			L			
N	ABN	N/A	N	ABN	N/A	
Shoulder						
___	___	___	___	___	___	ROM
___	___	___	___	___	___	Crepitus
___	___	___	___	___	___	Gen
___	___	___	___	___	___	Scars/Def.
Elbow						
___	___	___	___	___	___	Gen
___	___	___	___	___	___	TE Test
___	___	___	___	___	___	ROM
___	___	___	___	___	___	Tinels (u)
___	___	___	___	___	___	Scars/Def.
Hand/Wrist						
___	___	___	___	___	___	Gen
___	___	___	___	___	___	ROM
___	___	___	___	___	___	Tinels (m)
___	___	___	___	___	___	Phalens
___	___	___	___	___	___	Finklestein
___	___	___	___	___	___	Scars/Def.
Back						
___	___	___	___	___	___	Gen
___	___	___	___	___	___	ROM
___	___	___	___	___	___	Scars/Def.
Hips						
___	___	___	___	___	___	Gen
___	___	___	___	___	___	ROM
___	___	___	___	___	___	Scars/Def.
Knees						
___	___	___	___	___	___	Gen
___	___	___	___	___	___	ROM
___	___	___	___	___	___	Scars/Def.
___	___	___	___	___	___	Lig. Testing
Ankles						
___	___	___	___	___	___	Gen
___	___	___	___	___	___	ROM
___	___	___	___	___	___	Scars/Def.
Feet						
___	___	___	___	___	___	Gen
___	___	___	___	___	___	Scars/Def.

Neurological

N	ABN	N/A	
Cranial Nerves			
_____	_____	_____	II-XII

R			L			
N	ABN	N/A	N	ABN	N/A	
Upper Extremities						
Reflexes						
___	___	___	___	___	___	Biceps
___	___	___	___	___	___	BR
___	___	___	___	___	___	Triceps
Strength						
___	___	___	___	___	___	Shoulders
___	___	___	___	___	___	Elbows
___	___	___	___	___	___	Wrists
Lower Extremities						
Reflexes						
___	___	___	___	___	___	Patella
___	___	___	___	___	___	Achilles
Strength						
___	___	___	___	___	___	Hip
___	___	___	___	___	___	Knees
___	___	___	___	___	___	Ankles

_____ Rhomberg
_____ Tandem
_____ Squat

PhysicianComment:_____

_____

_____