MEDICAL HISTORY QUESTIONNAIRE

PHYSICALS

Date _____ Time _____

TYPE OF EXAMINATION

Pre-Employment [ ] Other [ ] _____

Name _____ Age_____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Height _____ Weight _____ Sex _____ Phone _____

Job Title _____ Company _____

The purpose of this questionnaire is to gather information concerning your health and physical condition,both now and in the past.
This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered.
Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave the question blank.

II. MEDICAL HISTORY

A. MEDICAL CONDITIONS/HISTORY

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
HEAD, NOSE, MOUTH & THROAT					
Persistent or severe headaches					
Frequent nose bleeds					
Persistent or severe sinus condition					
Bleeding gums					
Persistent or severe dental condition					
Hoarse when don't have cold					
Difficulty swallowing					
Persistent sore throat					
Loss of taste or smell					
Other:					
EARS AND HEARING					
Hearing difficulties					
Use hearing aid					
Ringing in ears (tinnitus)					
Perforated ear drum					
Persistent or severe ear infection					
Other:					
EYES AND VISION					
Glaucoma					
Cataracts					
Eye infection					
Vision problems					
Color blindness					
Injury to eye					
Eye surgery					
Double vision					
Glasses					

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
Contact lenses					
Other:					
RESPIRATORY SYSTEM					
Persistent or severe colds					
Persistent or severe cough					
Coughing up blood					
Asthma or wheezing					
Emphysema					
Pneumonia					
Tuberculosis					
Other:					
CARDIOVASCULAR SYSTEM					
Heart attack					
Stroke					
Hardening of arteries (atherosclerosis)					
High blood pressure					
Palpitations or irregular heartbeat					
Episodes of chest pains, discomfort					
Shortness of breath					
Varicose veins					
Swelling of ankles, feet, or legs (adema)					
Leg pains, cramps					
Other:					
GASTROINTESTINAL SYSTEM					
Persistent or severe nausea or indigestion					
Persistent or severe stomach pain					
Vomiting blood					
Persistent or severe vomiting					

Name: _____ Date of Birth: _____ Exam Date: _____

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
GASTROINTESTINAL SYSTEM CONTINUED					
Hernia (Rupture)					
Stomach or duodenal ulcer					
Colitis					
Hemorrhoids or piles					
Change in bowel habits					
Black stool					
Blood in stool					
Persistent or severe constipation					
Persistent or severe diarrhea					
Pancreatitis					
Other:					
LIVER, SPLEEN, AND GALLBLADDER					
Cirrhosis					
Hepatitis					
Jaundice					
Gallstones					
Other:					
KIDNEYS AND URINARY TRACT					
Kidney stones					
Kidney infection					
Blood in urine					
Pain or burning when urinating					
Frequent urination					
Albumin or protein in urine					
Prostate condition					
Burning/discharge from penis					
Other:					
REPRODUCTIVE SYSTEM					
Sterilization (vasectomy, tubal ligation, etc.)					
Diagnosed infertility problems					
Change in sexual ability					
Other:					
REPRODUCTIVE SYSTEM (FEMALES)					
Breast lumps					
Nipple discharge					
Reached menopause					
Painful menstruation					
Irregular periods					
Bleeding between periods					
Excessive bleeding in menstruation					
Significant change in periods					
Hysterectomy					
Pregnancy					
Difficulty becoming pregnant					
Sterilization (tubal ligation)					
Other:					
REPRODUCTIVE SYSTEM (MALES)					
Breast lumps					
Nipple discharge					
Erectile dysfunction					
Change in sexual ability					
Other:					
NEUROLOGICAL SYSTEM					
Epilepsy, convulsions, seizures					
Blackouts/loss of consciousness					
Fainting spells					
Dizzy spells (vertigo)					
Memory difficulty					
Tremor of the hands or head					
Paralysis of any type					
Cerebral palsy					
Muscle abnormalities					
Other:					
PSYCHOLOGICAL/MOOD					
Mental problem requiring hospitalization (nervous breakdown)					
Suicidal/attempted suicide					
Desired/sought psychological help					
Drug, narcotic or alcohol problem					
Persistent or severe depression/worry					
Persistent or severe difficulty sleeping					
Other:					
MUSCULOSKELETAL (Bones or joints)					
Arthritis					
Swollen or painful joints					
Bursitis or tendinitis					
Back pain					
Back surgery					
"Trick" or "locked" knee					
Knee surgery					
Painful or "trick" shoulder					
Chiropractic treatments					
Other:					
ENDOCRINE/METABOLIC SYSTEM					
Diabetes					
Thyroid condition or disease					
Hypoglycemia					
Unexplained weight gain					

Name: _____ Date of Birth: _____ Exam Date: _____

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
ENDOCRINE/METABOLIC SYSTEM CONTINUED					
Unexplained weight loss					
Unusual loss/growth of body hair					
Gout					
Osteoporosis or other bone disease					
Other:					
BLOOD/LYMPHATIC SYSTEM					
Anemia					
Bleeding disorder					
Sickle cell disease or trait					
Phlebitis/blood clot					
Blood transfusion					
Chills, fever, night sweats					
Swelling of lymph nodes or glands					
Other:					
CANCER					
Surgery					
Radiation therapy					
Chemotherapy					
Type of cancer, List:					
SKIN					
Dermatitis or eczema					
Hives					
Moles that bleed or get larger					
Change in color of skin					
Frequent boils/abscesses					
Acne					
Trouble with fingernails					
Small itching blisters on fingers/hands					
Sores that do not heal					
Other:					
ALLERGIES (Caused by:)					
Food					
Soaps or detergents					
Metals, chromium					
Nickel					
Rubber					
Epoxy Resins					
Plants (e.g., poison ivy, ect.)					
Pollen					
Insect scales					
Bee stings					
Animal dander (cats, dogs)					

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
ALLERGIES CONTINUED (Caused by:)					
House dust					
Industrial chemicals					
Other, List:					
INFECTIOUS OR CHILDHOOD DISEASES					
Meningitis/Encephalitis					
Polio					
Rheumatic fever					
Mumps					
Measles					
Venereal disease					
Other:					

IMMUNIZATION STATUS TITER OR IMMUNIZATION FOR:	EVER RECEIVED?			YEAR LAST RECEIVED (GIVE YEAR OR CHECK UNKNOWN)
	YES	NO	DON'T KNOW	YEAR OR UNKNOWN
Gamma globulin				
Hepatitis B				
Influenza				
Polio				
Rubella (measles)				
Smallpox				
Tetanus				
TB Test				
Other, List				

B. FAMILY HISTORY

HEALTH CONDITION OR DISEASE	TYPE OF RELATIVE		
	Mother/Father	Grandparent	Siblings/Children
Heart attack or heart disease or stroke			
High blood pressure			
Lung disease or respiratory condition			
Tuberculosis			
Severe loss of hearing before age of 50			
Glaucoma			
Thyroid disease or condition			
Ulcers or other stomach/intestinal condition			
Liver or gallbladder disease/condition			
Kidney disease/condition			
Convulsions/epilepsy			
Blood or lymph disease/condition			
Rheumatism/arthritis			
Mental condition; nervous breakdown; suicide			
Serious accident			
Cancer			
Age now or at death			

Name: _____ Date of Birth: _____ Exam Date: _____

C. MEDICATION HISTORY

MEDICATION	NOW TAKING		TAKEN IN THE LAST YEAR		ALLERGY
	YES	NO	YES	NO	(Check all that apply)
ADHD medication					
Anesthetics (e.g., novocaine)					
Antacids					
Antibiotics					
Anticoagulants					
Arthritis medicines					
Aspirin or aspirin substitutes					
Asthma medicine					
Birth control pills					
Blood pressure medication					
Cold medicines					
Cortisone or other steroids					
Diet pills					
Digitalis or other heart pills					
Diuretics/water pills					
Hormones					
Insulin					
Laxatives					
Marijauna					
Methadone					
Pain medicine (e.g., codeine, morphine					
Penicillin					
Sleeping pills					
Stimulants/caffeine					
Tetanus antitoxin					
Thyroid medication					
Tranquilizers/sedatives					
Vitamins					

LIST CURRENT MEDICATIONS

_____
_____
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DOSE AND FREQUENCY

_____
_____
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_____

D. SOCIAL HISTORY

1. Do you smoke cigarettes? ☐ YES ☐ NO

2. Have you ever smoked cigarettes in the past ☐ YES ☐ NO

3. If you now smoke, or smoked in the past, how many years total have you smoked? _____ years

4. If you now smoke, or have smoked in the past, how many packs per day do/did you smoke on average? (Choose the closest answer)

☐ 10 cigarettes or less ☐ More than 2 packs
☐ 1 pack
☐ 2 packs

5. Do you regularly drink alcoholic beverages? ☐ YES ☐ NO

6. If yes, how many drinks, beers, or glasses of wine do you think you drink daily?

☐ Less than 1 ☐ 5-6
☐ 1-2 ☐ 7-8
☐ 3-4 ☐ More than 8

7. Do you exercise strenuously for at least 30 minutes:

☐ Daily ☐ Rarely
☐ Three times a week ☐ Never
☐ One time a week

8. Do you feel frustrated, stressed, or uptight?

☐ Daily ☐ Rarely
☐ Three times a week ☐ Never
☐ One time a week

9. Do you eat fatty or greasy foods?

☐ Daily ☐ Rarely
☐ Three times a week ☐ Never
☐ One time a week

Name: _____ Date of Birth: _____ Exam Date: _____

E. SURGICAL HISTORY

Have you ever had surgery? [ ] YES [ ] NO

TYPE OF SURGERY	YEAR	LOCATION OF HOSPITAL/SURGEON	COMPLICATIONS, IF ANY

F. HISTORY OF HOSPITALIZATION

Have you ever been hospitalized? [ ] YES [ ] NO

If 'yes', complete the following information about hospitalization.

PART OF BODY AFFECTED	NATURE OF ILLNESS OR REASON FOR HOSPITALIZATION	DATE (Month/Year)	Work Related?	IF "YES", EMPLOYER NAME

D. General Questions

1. Have you ever been denied life or health insurance or offered it only at additional rates?	[ ] YES	[ ] NO
2. Have you ever been denied employment for health reasons?	[ ] YES	[ ] NO
3. Have you ever been disqualified for entry into or discharged from the Armed Services for medical reasons?	[ ] YES	[ ] NO
4. Have you ever received, is there pending, have you applied for, or do you intend to apply for a pension or compensation	[ ] YES	[ ] NO
5. Have you ever had to change jobs for health reasons?	[ ] YES	[ ] NO
6. Do you currently have any health condition that may limit your performance of any type of task or job?	[ ] YES	[ ] NO
7. Are you currently partially disabled or impaired in any way (other than corrected vision)?	[ ] YES	[ ] NO
8. Are you currently under treatment or observation for any physical or mental health condition?	[ ] YES	[ ] NO
9. Have you ever received disability compensation from the Armed Services?	[ ] YES	[ ] NO
10. Have you ever received a disability retirement from a civilian job?	[ ] YES	[ ] NO

New Patient Demographics - Website Form

Patient Demographic Information

Patient Name (Last, First, Middle) _____ Nickname _____

SSN _____ Birth Date _____ Age _____ Sex _____

Address _____ City, State, ZIP _____

Home Phone _____ Cell Phone _____

Email Address _____

Emergency Contact Name _____ Emergency Contact Phone _____

Marital Status _____ Race _____ Ethnicity _____

Preferred Language _____ Employer _____

Primary Care Physician (Name, Address, Phone Number) _____

How did you hear about us: *Select one*

☐ Patient Referral ☐ Provider referral: _____ ☐ Insurance referral ☐ Web search

☐ Social Media ☐ Event ☐ Direct Mail or Magazine ☐ Radio/TV ☐ Billboard ☐ Other: _____

Responsible Party Information (if different than above or if patient is a minor)

Guarantor Name (Last, First) _____ Relationship _____

SSN _____ Birth Date _____ Sex _____

Address _____ City, State, ZIP _____

Home Phone _____ Cell Phone _____

Email Address

Insurance Information

DO NOT FILL OUT THIS SECTION FOR PHYSICALS

Primary Insurance	Secondary Insurance
Policy Holder Name	Policy Holder Name
Relationship to Patient	Relationship to Patient
Policy Holder DOB	Policy Holder DOB
Policy # / Member ID	Policy # / Member ID
Group #	Group #

Patient / Guarantor Signature _____ Date _____

PULSE urgent care center

Tuberculin/PPD Testing Questionnaire

Patient Information:

Name: _____ Date of Birth: _____

Employer: _____

PLEASE CIRCLE YOUR ANSWER:

1. Have you ever had a TB/PPD skin test administered before? Yes No
2. Have you ever tested positive for TB? Yes No
   If yes, when? _____
3. Have you been treated for TB by a physician? This means you have had active Tuberculosis and received treatment. Yes No
4. Are you currently pregnant? Yes No
5. Have you ever received the BCG vaccine**? Yes No

IF YES DO NOT PROCEED WITH SKIN TEST

**Bacille Calmette-Guerin vaccine (BCG) is a vaccine for tuberculosis that is received by those who reside in countries at high risk for tuberculosis infection. It is not administered in the United States, Canada, Australia, New Zealand, and those from Northern or Western Europe)

I request and consent to receive the Tuberculin/PPD test. I understand that the Tuberculin/PPD skin testing upon employment is a requirement of the position unless I can provide documentation of a prior negative skin test result, prior treatment for tuberculosis infection or prior tuberculosis disease.

I understand that the TB skin test must be read by medical professionals within **48-72 HOURS** after the test has been administered. If reading is not complete in the time frame below, the test must be re-done.

Employee / Patient Signature: _____ Date: _____

For Office Use Only:

Test Administration:

Date: _____ Time: _____am/pm Site: □RLFA □LLFA

Lot Number: _____ Exp. Date: _____ Administrator: _____

TEST READ: **AFTER** _____ **Time:** _____ **or BEFORE Date:** _____ **Time:** _____

Results:

Date: _____ Time: _____am/pm Read by: _____

Induration: _____mm Erythema: _____mm

Result: □ Negative □ Positive □ Chest X-Ray confirmation indicated □ Invalid *(requires new placement)*

Results Recorded By: _____

100 E Cypress Ave.
Redding, CA 96002
(P) 530-722-1111 (F) 530-722-9999

PULSE
Urgent Care Center

Medical History Questionnaire
Instructions and Authorization

Please read carefully the following instructions for filling out this questionnaire. Complete and accurate forms will assist in your physical moving quickly and efficiently.

1. This questionnaire is a legal document.

2. The purpose of this questionnaire is to gather information concerning your health and physical condition, both current and past.

3. The information will be used for the sole purpose of determining whether you are physically and mentally healthy enough to safely perform the duties of the position for which you are being considered.

4. You must answer all of the following questions as fully and completely as you can. Withholding or falsifying information will result in immediate disqualification for the position in which you are being considered.

5. **EACH QUESTION MUST BE ANSWERED INDIVIDUALLY:** Please check mark each box. A continuous line or other indication that all answers are the same will not be accepted and will cause a delay in the physical process.

6. If you do not understand a question or are unsure of how to answer please leave the question blank. The provider or other medical staff will provide clarification.

READ BEFORE SIGNING

I agree to participate in a physical examination to determine the current state of my physical condition. I also authorize the examining physician to release the information from this examination to

I agree that if any misrepresentation or omission has been made by me on any matter concerning this examination, including my statements on this form, any offer of employment may be withdrawn or my employment terminated immediately without any obligation or liability to me other than for payment at the rate agreed upon for service actually rendered if I had been employed.

Signature

Date

MEDICAL HISTORY QUESTIONNAIRE

PHYSICALS

Date _____ Time _____

TYPE OF EXAMINATION

Pre-Employment [ ] Other [ ] _____

Name _____ Age_____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Height _____ Weight _____ Sex _____ Phone _____

Job Title _____ Company _____

The purpose of this questionnaire is to gather information concerning your health and physical condition,both now and in the past.
This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered.
Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave the question blank.

II. MEDICAL HISTORY

A. MEDICAL CONDITIONS/HISTORY

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
HEAD, NOSE, MOUTH & THROAT					
Persistent or severe headaches					
Frequent nose bleeds					
Persistent or severe sinus condition					
Bleeding gums					
Persistent or severe dental condition					
Hoarse when don't have cold					
Difficulty swallowing					
Persistent sore throat					
Loss of taste or smell					
Other:					
EARS AND HEARING					
Hearing difficulties					
Use hearing aid					
Ringing in ears (tinnitus)					
Perforated ear drum					
Persistent or severe ear infection					
Other:					
EYES AND VISION					
Glaucoma					
Cataracts					
Eye infection					
Vision problems					
Color blindness					
Injury to eye					
Eye surgery					
Double vision					
Glasses					

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
Contact lenses					
Other:					
RESPIRATORY SYSTEM					
Persistent or severe colds					
Persistent or severe cough					
Coughing up blood					
Asthma or wheezing					
Emphysema					
Pneumonia					
Tuberculosis					
Other:					
CARDIOVASCULAR SYSTEM					
Heart attack					
Stroke					
Hardening of arteries (atherosclerosis)					
High blood pressure					
Palpitations or irregular heartbeat					
Episodes of chest pains, discomfort					
Shortness of breath					
Varicose veins					
Swelling of ankles, feet, or legs (adema)					
Leg pains, cramps					
Other:					
GASTROINTESTINAL SYSTEM					
Persistent or severe nausea or indigestion					
Persistent or severe stomach pain					
Vomiting blood					
Persistent or severe vomiting					

Name: _____ Date of Birth: _____ Exam Date: _____

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
GASTROINTESTINAL SYSTEM CONTINUED					
Hernia (Rupture)					
Stomach or duodenal ulcer					
Colitis					
Hemorrhoids or piles					
Change in bowel habits					
Black stool					
Blood in stool					
Persistent or severe constipation					
Persistent or severe diarrhea					
Pancreatitis					
Other:					
LIVER, SPLEEN, AND GALLBLADDER					
Cirrhosis					
Hepatitis					
Jaundice					
Gallstones					
Other:					
KIDNEYS AND URINARY TRACT					
Kidney stones					
Kidney infection					
Blood in urine					
Pain or burning when urinating					
Frequent urination					
Albumin or protein in urine					
Prostate condition					
Burning/discharge from penis					
Other:					
REPRODUCTIVE SYSTEM					
Sterilization (vasectomy, tubal ligation, etc.)					
Diagnosed infertility problems					
Change in sexual ability					
Other:					
REPRODUCTIVE SYSTEM (FEMALES)					
Breast lumps					
Nipple discharge					
Reached menopause					
Painful menstruation					
Irregular periods					
Bleeding between periods					
Excessive bleeding in menstruation					
Significant change in periods					
Hysterectomy					
Pregnancy					

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
Difficulty becoming pregnant					
Sterilization (tubal ligation)					
Other:					
REPRODUCTIVE SYSTEM (MALES)					
Breast lumps					
Nipple discharge					
Erectile dysfunction					
Change in sexual ability					
Other:					
NEUROLOGICAL SYSTEM					
Epilepsy, convulsions, seizures					
Blackouts/loss of consciousness					
Fainting spells					
Dizzy spells (vertigo)					
Memory difficulty					
Tremor of the hands or head					
Paralysis of any type					
Cerebral palsy					
Muscle abnormalities					
Other:					
PSYCHOLOGICAL/MOOD					
Mental problem requiring hospitalization (nervous breakdown)					
Suicidal/attempted suicide					
Desired/sought psychological help					
Drug, narcotic or alcohol problem					
Persistent or severe depression/worry					
Persistent or severe difficulty sleeping					
Other:					
MUSCULOSKELETAL (Bones or joints)					
Arthritis					
Swollen or painful joints					
Bursitis or tendinitis					
Back pain					
Back surgery					
"Trick" or "locked" knee					
Knee surgery					
Painful or "trick" shoulder					
Chiropractic treatments					
Other:					
ENDOCRINE/METABOLIC SYSTEM					
Diabetes					
Thyroid condition or disease					
Hypoglycemia					
Unexplained weight gain					

Name: _____ Date of Birth: _____ Exam Date: _____

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
ENDOCRINE/METABOLIC SYSTEM CONTINUED					
Unexplained weight loss					
Unusual loss/growth of body hair					
Gout					
Osteoporosis or other bone disease					
Other:					
BLOOD/LYMPHATIC SYSTEM					
Anemia					
Bleeding disorder					
Sickle cell disease or trait					
Phlebitis/blood clot					
Blood transfusion					
Chills, fever, night sweats					
Swelling of lymph nodes or glands					
Other:					
CANCER					
Surgery					
Radiation therapy					
Chemotherapy					
Type of cancer, List:					
SKIN					
Dermatitis or eczema					
Hives					
Moles that bleed or get larger					
Change in color of skin					
Frequent boils/abscesses					
Acne					
Trouble with fingernails					
Small itching blisters on fingers/hands					
Sores that do not heal					
Other:					
ALLERGIES (Caused by:)					
Food					
Soaps or detergents					
Metals, chromium					
Nickel					
Rubber					
Epoxy Resins					
Plants (e.g., poison ivy, ect.)					
Pollen					
Insect scales					
Bee stings					
Animal dander (cats, dogs)					

HEALTH CONDITION	NEVER	PAST	NOW	DON'T KNOW	DATE (Month & Year)
ALLERGIES CONTINUED (Caused by:)					
House dust					
Industrial chemicals					
Other, List:					
INFECTIOUS OR CHILDHOOD DISEASES					
Meningitis/Encephalitis					
Polio					
Rheumatic fever					
Mumps					
Measles					
Venereal disease					
Other:					

IMMUNIZATION STATUS TITER OR IMMUNIZATION FOR:	EVER RECEIVED?			YEAR LAST RECEIVED (GIVE YEAR OR CHECK UNKNOWN)
	YES	NO	DON'T KNOW	YEAR OR UNKNOWN
Gamma globulin				
Hepatitis B				
Influenza				
Polio				
Rubella (measles)				
Smallpox				
Tetanus				
TB Test				
Other, List				

B. FAMILY HISTORY

HEALTH CONDITION OR DISEASE	TYPE OF RELATIVE		
	Mother/Father	Grandparent	Siblings/Children
Heart attack or heart disease or stroke			
High blood pressure			
Lung disease or respiratory condition			
Tuberculosis			
Severe loss of hearing before age of 50			
Glaucoma			
Thyroid disease or condition			
Ulcers or other stomach/intestinal condition			
Liver or gallbladder disease/condition			
Kidney disease/condition			
Convulsions/epilepsy			
Blood or lymph disease/condition			
Rheumatism/arthritis			
Mental condition; nervous breakdown; suicide			
Serious accident			
Cancer			
Age now or at death			

Name: _____ Date of Birth: _____ Exam Date: _____

C. MEDICATION HISTORY

MEDICATION	NOW TAKING		TAKEN IN THE LAST YEAR		ALLERGY
	YES	NO	YES	NO	(Check all that apply)
ADHD medication					
Anesthetics (e.g., novocaine)					
Antacids					
Antibiotics					
Anticoagulants					
Arthritis medicines					
Aspirin or aspirin substitutes					
Asthma medicine					
Birth control pills					
Blood pressure medication					
Cold medicines					
Cortisone or other steroids					
Diet pills					
Digitalis or other heart pills					
Diuretics/water pills					
Hormones					
Insulin					
Laxatives					
Marijauna					
Methadone					
Pain medicine (e.g., codeine, morphine					
Penicillin					
Sleeping pills					
Stimulants/caffeine					
Tetanus antitoxin					
Thyroid medication					
Tranquilizers/sedatives					
Vitamins					

LIST CURRENT MEDICATIONS	DOSE AND FREQUENCY

D. SOCIAL HISTORY

1. Do you smoke cigarettes? ☐ YES ☐ NO

2. Have you ever smoked cigarettes in the past ☐ YES ☐ NO

3. If you now smoke, or smoked in the past, how many years total have you smoked? _____ years

4. If you now smoke, or have smoked in the past, how many packs per day do/did you smoke on average? (Choose the closest answer)

☐ 10 cigarettes or less ☐ More than 2 packs
☐ 1 pack
☐ 2 packs

5. Do you regularly drink alcoholic beverages? ☐ YES ☐ NO

6. If yes, how many drinks, beers, or glasses of wine do you think you drink daily?

☐ Less than 1 ☐ 5-6
☐ 1-2 ☐ 7-8
☐ 3-4 ☐ More than 8

7. Do you exercise strenuously for at least 30 minutes:

☐ Daily ☐ Rarely
☐ Three times a week ☐ Never
☐ One time a week

8. Do you feel frustrated, stressed, or uptight?

☐ Daily ☐ Rarely
☐ Three times a week ☐ Never
☐ One time a week

9. Do you eat fatty or greasy foods?

☐ Daily ☐ Rarely
☐ Three times a week ☐ Never
☐ One time a week

Name: _____ Date of Birth: _____ Exam Date: _____

E. SURGICAL HISTORY

Have you ever had surgery? [ ] YES [ ] NO

TYPE OF SURGERY	YEAR	LOCATION OF HOSPITAL/SURGEON	COMPLICATIONS, IF ANY

F. HISTORY OF HOSPITALIZATION

Have you ever been hospitalized? [ ] YES [ ] NO

If 'yes', complete the following information about hospitalization.

PART OF BODY AFFECTED	NATURE OF ILLNESS OR REASON FOR HOSPITALIZATION	DATE (Month/Year)	Work Related?	IF "YES", EMPLOYER NAME

D. General Questions

1. Have you ever been denied life or health insurance or offered it only at additional rates? [ ] YES [ ] NO

2. Have you ever been denied employment for health reasons? [ ] YES [ ] NO

3. Have you ever been disqualified for entry into or discharged from the Armed Services for medical reasons? [ ] YES [ ] NO

4. Have you ever received, is there pending, have you applied for, or do you intend to apply for a pension or compensation [ ] YES [ ] NO

5. Have you ever had to change jobs for health reasons? [ ] YES [ ] NO

6. Do you currently have any health condition that may limit your performance of any type of task or job? [ ] YES [ ] NO

7. Are you currently partially disabled or impaired in any way (other than corrected vision)? [ ] YES [ ] NO

8. Are you currently under treatment or observation for any physical or mental health condition? [ ] YES [ ] NO

9. Have you ever received disability compensation from the Armed Services? [ ] YES [ ] NO

10. Have you ever received a disability retirement from a civilian job? [ ] YES [ ] NO