OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM
MEDICAL HISTORY UPDATE FORM

(See Form ARS-182A/B for Privacy Act Notification)

*A record of what has happened **since your last USDA/ARS examination** is very important. Please complete this confidential questionnaire by placing a check mark (**T**) in the appropriate spaces or printing other information where requested. (Use black or blue ink.)*

SECTION 1 – IDENTIFICATION

1. NAME *(Last, first, middle initial)*	2. SEX ☐ FEMALE ☐ MALE	3. SOCIAL SECURITY NUMBER	4. DATE OF BIRTH

5. CURRENT MAILING ADDRESS *(Where confidential mail can be delivered)*

6. WHAT YEAR DID YOU START WORK WITH USDA/ARS?

7. HAS THE FOLLOWING INFORMATION CHANGED SINCE YOUR LAST EXAMINATION:
☐ JOB TITLE/SERIES ☐ WORK LOCATION ☐ HOME ADDRESS

7A. NEW JOB TITLE/SERIES: _____

7B. NEW WORK LOCATION: _____

SECTION 2 – MEDICATIONS

LIST ALL MEDICATIONS YOU CURRENTLY TAKE *(Including prescription, non-prescription, vitamins and herbal preparations*)

SECTION 3 – SOCIAL HISTORY

1. HAVE YOU EVER USED TOBACCO? ☐ YES ☐ NO

IF YES: ☐ CURRENT ☐ PAST YEARS SINCE QUITTING? _____

WHAT TYPE: ☐ CIGARETTE ☐ PIPE/CIGAR ☐ SNUFF/CHEWING

AMOUNT PER DAY? _____ HOW MANY YEARS? _____

2. WHAT IS YOUR AVERAGE ALCOHOL CONSUMPTION IN A WEEK *(one drink = 12 oz. beer or one glass of wine or 1.5 oz. liquor)?*

_____ DRINKS

HOW OFTEN DO YOU DRINK ALCOHOL?
☐ WEEKDAYS ☐ WEEKENDS ☐ BOTH

SECTION 4 – MEDICAL HISTORY *(Since your last USDA/ARS exam)*

HAS YOUR DOCTOR DIAGNOSED YOU WITH ANY OF THE FOLLOWING CONDITIONS?

☐ ALLERGIES *(specify):* _____

☐ ANEMIA
☐ ASTHMA
☐ CLAUSTROPHOBIA
☐ COLLAPSED LUNG
☐ DIABETES
☐ EMPHYSEMA
☐ HEART ATTACK
☐ HEART MURMUR
☐ HEPATITIS
☐ HERNIATED DISC
☐ HIGH BLOOD PRESSURE
☐ KIDNEY DISEASE
☐ MIGRAINES
☐ POSITIVE SKIN TEST FOR TB
☐ PROSTATE PROBLEMS
☐ RUPTURED EAR DRUM
☐ SEIZURES
☐ THYROID TROUBLE

☐ OTHER MEDICAL DISORDERS *(specify)*: _____

SECTION 5 – HOSPITALIZATIONS *(Since your last USDA/ARS exam)*

INCLUDE ANY OUTPATIENT SERVICES/PROCEDURES.

YEAR	REASON

SECTION 6 – OCCUPATIONAL HISTORY *(Since your last USDA/ARS exam)*

1. HAVE YOUR JOB EXPOSURES/DUTIES CHANGED? ☐ YES ☐ NO
IF YES, DESCRIBE:

2. HAVE YOU HAD ANY INJURY/ILLNESS WHICH YOU THINK MAY BE WORK RELATED? IF YES, DESCRIBE. ☐ YES ☐ NO

SECTION 7 – REVIEW OF SYSTEMS *(Since your last USDA/ARS exam)*

WHICH OF THE FOLLOWING HAVE BEEN A PROBLEM?

GENERAL/CONSTITUTIONAL
☐ FEVER > 100
☐ SHIVERING/CHILLS
☐ GENERALIZED WEAKNESS
☐ UNEXPLAINED WEIGHT LOSS/GAIN
☐ EXCESSIVE FATIGUE
☐ SWOLLEN GLANDS
☐ SUDDEN LOSS OF CONSCIOUSNESS
☐ LOSS OF APPETITE
☐ HEAD INJURY

HEART/LUNGS
☐ CHEST PAIN OR PRESSURE
☐ IRREGULAR HEART BEAT
☐ PALPITATIONS/SKIPPED BEATS
☐ NEW OR CHANGED COUGH
☐ COUGHING UP BLOOD
☐ WHEEZING
☐ SHORTNESS OF BREATH

NEUROLOGIC/PSYCHIATRIC
☐ HEADACHES
☐ DEPRESSION
☐ NUMBNESS OR TINGLING
☐ EXCESSIVE ANXIETY
☐ INSOMNIA/DIFFICULTY SLEEPING
☐ LOSS OF MEMORY

EARS/NOSE/THROAT
☐ DIFFICULTY HEARING
☐ RINGING, BUZZING
☐ SINUS TROUBLE
☐ SNEEZING/RUNNY NOSE
☐ NOSEBLEEDS
☐ DIFFICULTY SWALLOWING
☐ DRY MOUTH
☐ DIZZINESS

SECTION 7 – REVIEW OF SYSTEMS *(Continued)*

WHICH OF THE FOLLOWING HAVE BEEN A PROBLEM?

GENITOURINARY AND REPRODUCTIVE

- ☐ DIFFICULT OR PAINFUL URINATION
- ☐ BLOOD IN URINE

MEN ONLY

- ☐ LUMP IN TESTICLE
- ☐ IMPOTENCE

WOMEN ONLY

- ☐ BREAST LUMP/DISCHARGE
- ☐ CURRENTLY OR POSSIBLY PREGNANT

DIGESTIVE SYSTEM

- ☐ NAUSEA/VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ RECTAL BLEEDING OR BLACK TARRY STOOLS
- ☐ YELLOW JAUNDICE
- ☐ ABDOMINAL PAIN

EYES

- ☐ CHANGE IN VISION
- ☐ ITCHING
- ☐ TEARING

SKIN/MUSCULOSKELETAL

- ☐ RASHES
- ☐ MOLES THAT CHANGED IN SIZE OR COLOR
- ☐ MUSCLE PAIN
- ☐ BACK PAIN
- ☐ NECK PAIN
- ☐ WEAKNESS IN ARMS/LEGS
- ☐ JOINT PAIN

TEETH/GUM DISEASE

- ☐ SPECIFY: _____

EXAMINER'S COMMENTS *(All positive responses in the Medical History (Section 4) and Review of Systems (Section 7) must be clarified here.)*

SECTIONS 8 AND 9 : *The purpose of these sections is to accumulate as much information as possible from ARS employees to determine the existence of clusters or other "sentinel" events that would cause further study. While we realize some of these questions are quite personal, complete information is extremely important and no identifying information will be released.*

SECTION 8 – REPRODUCTIVE HISTORY

1. HAVE YOU OR YOUR PARTNER EVER HAD A PROBLEM CONCEIVING A CHILD? ☐ YES ☐ NO

   IF YES, SPECIFY: ☐ SELF ☐ PRESENT PARTNER ☐ PREVIOUS PARTNER

2. HAVE YOU OR YOUR PARTNER CONSULTED A PHYSICIAN FOR A FERTILITY OR ☐ YES ☐ NO

   IF YES, SPECIFY WHO CONSULTED THE PHYSICIAN:

   ☐ SELF ☐ PARTNER ☐ SELF AND PARTNER

   IF YES. SPECIFY THE DIAGNOSIS:

3. HAVE YOU EVER CONCEIVED A CHILD RESULTING IN A *(check all that apply)*:

   ☐ DEFORMED OFFSPRING ☐ MISCARRIAGE ☐ STILL BIRTH

   IF OUTCOME WAS A DEFORMED OFFSPRING, WHAT WAS THE DEFORMITY?

   WAS THIS OUTCOME A RESULT OF A PREGNANCY OF YOURS WITH:

   ☐ PRESENT PARTNER ☐ A PRIOR PARTNER

4. DID THE TIMING OF ANY ABNORMAL PREGNANCY OUTCOME COINCIDE WITH YOUR PRESENT EMPLOYMENT? ☐ YES ☐ NO

   LIST DATES OF OCCURRENCES:

5. WHAT IS THE OCCUPATION OF YOUR PARTNER?

WOMEN ONLY

6. DO YOU HAVE MENSTRUAL PERIODS? ☐ YES ☐ NO

   IF NO, HAVE YOU ENTERED OR COMPLETED MENOPAUSE? ☐ YES ☐ NO

7. HAVE YOU HAD MENSTRUAL IRREGULARITIES? ☐ YE ☐ NO

7A. IF YES, SPECIFY THE TYPE:	7B. DATE BEGAN	7C. DATE ENDED

SECTION 9 – CANCER HISTORY

1. HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? ☐ YES ☐ NO

2. DID YOU HAVE SPECIFIC TISSUE DIAGNOSIS *(e.g., for skin cancer: basal cell, squamous cell, etc.; for lung cancer: adenocarcinoma, squamous cell carcinoma, "oat" cell, etc.)? If so, complete the following:*

DATE DIAGNOSED	CANCER	TISSUE TYPE

EMPLOYEE SIGNATURE	SOCIAL SECURITY NUMBER	DATE COMPLETED