SOCIAL SECURITY NO.

The Social Security Number fields have been removed from this form.

OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM

# MEDICAL HISTORY

**CARDIOVASCULAR**: Have you ever had or do you now have any of the following illnesses or problems with your heart or blood vessels?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Heart Attack | | | |
| Angina Pectoris | | | |
| Heart Murmur | | | |
| Enlarged Heart | | | |
| Stroke | | | |
| High Blood Pressure | | | |
| Other problems with blood pressure | | | |
| Episodes of chest pains, tightness, discomfort | | | |
| Rheumatic Heart Disease | | | |
| Arteriosclerosis | | | |
| Varicose Veins | | | |
| Other *(specify):* | | | |
| Have you ever had heart surgery? *(If yes, describe):* | | | |

**RESPIRATORY ILLNESS/CONDITIONS:**

Have you had or do you now have any of the following illnesses or problems with your lungs?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Frequent Colds | | | |
| Coughed up Blood | | | |
| Chronic Cough | | | |
| Lung or Breathing difficulties or Shortness of Breath | | | |
| Asthma | | | |
| Emphysema | | | |
| Pneumonia | | | |
| Tuberculosis | | | |
| Bronchitis | | | |
| Pleurisy | | | |
| Other *(specify):* | | | |
| Have you ever had surgery on your lungs? *(If yes, describe):* | | | |

Have you ever had or do you now have any of the following problems with your mouth, nose or throat?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Nasal passages frequently irritated | | | |
| Nose Bleeds often | | | |
| Throat is often irritated | | | |
| Voice is hoarse when you do not have a cold | | | |
| Mouth/Gums frequently have sores/ulcers | | | |
| Gums shrinking, irritated or bleeding | | | |
| Other *(specify):* | | | |

**ENDOCRINE:** Have you ever had or do you now have any of the following illnesses or conditions?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Hypoglycemia | | | |
| Diabetes | | | |
| Goiter | | | |
| Thyroid disease or disorder | | | |
| Swollen glands or nodes | | | |
| Pancreatitis | | | |
| Other gland problems *(specify):* | | | |

**DIGESTIVE SYSTEM:** Have you ever had or do you now have any of the following illnesses or problems with your digestive system?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Blood in stool | | | |
| Stomach or Duodenal Ulcer | | | |
| Appendicitis | | | |
| Nervous stomach | | | |
| Colitis | | | |
| Frequent constipation | | | |
| Frequent diarrhea | | | |
| Frequent indigestion | | | |
| Stomach pain | | | |
| Hiatal hernia or rupture | | | |
| Diverticulitis | | | |
| Hemorrhoids or piles | | | |
| Other *(specify):* | | | |
| Have you ever had surgery on your digestive system? *(If yes, describe):* | | | |

**LIVER AND SPLEEN:** Have you ever or do you now have any of the following illnesses or problems with your liver, spleen, or gallbladder?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Cirrhosis of the liver | | | |
| Hepatitis | | | |
| Jaundice | | | |
| Gallbladder disease | | | |
| Gallbladder stones | | | |
| Injury to your spleen | | | |
| Other *(specify):* | | | |
| Have you ever had surgery on your liver or spleen? *(If yes, describe):* | | | |

**KIDNEYS/URINARY TRACT:** Have you ever had or do you now have any of the following illnesses or problems with your kidneys or urinary tract?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Blood in urine | | | |
| Pain or burning when urinating | | | |
| Kidney disease | | | |
| Kidney infection | | | |
| Kidney stones | | | |
| Nephritis *(Bright's Disease)* | | | |
| Bladder Infection | | | |
| Prostate gland enlargement/infection *(Males only)* | | | |
| Tumor in urinary tract | | | |
| Other *(specify):* | | | |
| Have you ever had surgery on your kidneys or urinary tract? *(If yes, describe):* | | | |

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# MEDICAL HISTORY *(Continued)*

**REPRODUCTIVE HISTORY** *(please answer all four questions):*

**a.** Have you or your partner ever had a problem conceiving a child? ☐ Yes ☐ No

If yes, specify: ☐ Self ☐ Present Partner ☐ Previous Partner

**b.** Have you or your partner consulted a physician for a fertility or other reproductive problem? ☐ Yes ☐ No

If yes, specify who consulted the physician:

☐ Self ☐ Partner ☐ Self and Partner

If yes, specify the diagnosis:

**c.** Have you or your partner ever conceived a child resulting in a miscarriage, still birth or deformed offspring? ☐ Yes ☐ No

If yes, specify: ☐ Miscarriage ☐ Still Birth ☐ Deformed Offspring

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

**d.** Did the timing of any abnormal pregnancy outcome coincide with your present employment? ☐ Yes ☐ No

List dates of occurrences:

What is the occupation of your partner?

**NERVOUS SYSTEM:** Have you ever had or do you now have any of the following illnesses or problems with your nervous system?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Frequent headaches | | | |
| Migraine headaches | | | |
| Epilepsy, convulsions, seizures | | | |
| Nervous breakdown | | | |
| Depression/Excessive worry | | | |
| Loss of memory *(amnesia)* | | | |
| Nervousness | | | |
| Tremor of the hands or head | | | |
| Palsey or tremors | | | |
| Severe head injury | | | |
| Neuritis | | | |
| Paralysis of any type | | | |
| Other problems *(specify):* | | | |

**BLOOD:** Have you ever had or do you now have any of the following blood diseases or problems?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Anemia | | | |
| Low hemoglobin | | | |
| Bleeding disorder | | | |
| Leukemia | | | |
| Sickle cell disease or trait | | | |
| Phlebitis | | | |
| Other problems *(specify):* | | | |
| Have you ever had a blood transfusion? | | | |

**BONES AND JOINTS:** Have you ever had or do you now have any of the following problems with your bones or joints?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Arthritis or Rheumatism | | | |
| Gout | | | |
| Joint pains | | | |
| Bone infections | | | |
| Bursitis or tendonitis | | | |
| Backache, back trouble, sciatica | | | |
| Foot trouble, flat feet or fallen arches | | | |
| "Trick", "locked", or "loose" knee | | | |
| Back injury or herniated disk | | | |
| Painful or trick shoulder | | | |
| Swollen or painful joints | | | |
| Other problems with your bones or joints *(If yes, specify):* | | | |

Have you ever had surgery *(including setting of broken bones)* on any of your bones or joints? *(If yes, describe):*

**SKIN:** Have you ever had or do you now have any of the following skin problems?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Hives | | | |
| Eczema | | | |
| Psoriasis | | | |
| Rash on elbows, knees, or scalp | | | |
| Rash other than on elbows, knees, or scalp | | | |
| Severe stubborn dandruff | | | |
| Small itching blisters on the sides of your fingers or palms | | | |
| Excessive sweating on palms, soles, or armpits | | | |
| Sores that do not heal | | | |
| Moles that bleed or get larger | | | |
| Change in color of skin *(other than suntan)* | | | |
| New growth on skin | | | |
| Other *(If yes, describe):* | | | |

ALLERGIES: Have you ever had or do you now have any allergies?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Medications *(If yes, please list):* | | | |

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Food | | | |
| Soaps or detergents | | | |
| Chromium | | | |
| Nickel | | | |
| Rubber | | | |
| Epoxy resins | | | |
| Plants *(e.g., poison ivy, etc.)* | | | |
| Pollen | | | |
| Insect scales | | | |
| Bee stings | | | |

**(NOTE: This section continues at top of next page.)**

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# MEDICAL HISTORY *(Continued)*

**ALLERGIES** *(Continued)*

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| House dust | | | |
| Animal dander, feathers, or fur | | | |
| Sunlight or cold | | | |
| Other *(If yes, please list):* | | | |
| *Do you react with:* | | | |
| Rash | | | |
| Hives | | | |
| Hay fever symptoms | | | |
| Breathing difficulty | | | |
| Other *(If yes, describe):* | | | |

**EARS:** Have you ever had or do you now have any of the following problems with your ears or your hearing?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Difficulty in hearing | | | |
| Tinnitus *(ringing/buzzing)* in right ear | | | |
| in left ear | | | |
| Nasal allergy | | | |
| Vertigo *(dizziness)* | | | |
| Perforation of the ear drum | | | |
| Ear drainage *(caused by infection or injury)* | | | |
| High fever | | | |
| Infection of inner ear | | | |
| Hearing loss by blood relatives *(such as grandparents, parents, aunts, uncles, brothers, or sisters)* before they reached the age of 60 | | | |
| Other problems with your ears *(If yes, describe):* | | | |

**EYES:** Have you ever had or do you now have any of the following problems with your eyes or your vision?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Glaucoma | | | |
| Cataracts | | | |
| Conjunctivitis *(pink eye)* | | | |
| Blurring of eyesight | | | |
| Vision getting worse | | | |
| Seeing double | | | |
| Seeing halos around lights | | | |
| Pain in the eyeball | | | |
| Eyes are often bloodshot | | | |
| Right eye / Left eye — Injured *(e.g., scratched, burned, cut, etc.)* | | | |
| Right eye / Left eye — Foreign object accidentally embedded in the eye | | | |
| Other problems with your eyes *(If yes, describe):* | | | |
| Do you wear glasses? | | | |
| Do you wear contact lenses? | | | |

**CANCER:** Have you ever been diagnosed with cancer?
☐ No ☐ Yes *(If yes, list the year and type of diagnosis.)*

| Type | Year | Specific Tissue Diagnosis *(If available)* |
|---|---|---|
| Skin | | |
| Colon | | |
| Breast | | |
| Lung | | |
| Prostate | | |
| Cervical | | |

Other *(If yes, specify type and describe tissue diagnosis and year):*

**INFECTIOUS/CHILDHOOD DISEASES**: Have you had or do you now have:

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Mononucleosis | | | |
| Meningitis | | | |
| Malaria | | | |
| Polio | | | |
| Rheumatic fever | | | |
| Scarlet fever | | | |
| Mumps | | | |
| Measles | | | |
| Chicken pox | | | |
| German measles | | | |
| Tonsillitis | | | |
| Gonorrhea | | | |
| Syphilis | | | |

**FAMILY HISTORY:** Have any of your blood relatives *(parents, grandparents, sisters, aunts, uncles or children)* had any of the following illnesses or conditions?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Anemia | | | |
| Alcoholism | | | |
| Allergies | | | |
| Arthritis | | | |
| Asthma | | | |
| Bleeding disorders *(free bleeder)* | | | |
| Breast cancer | | | |
| Cervical cancer | | | |
| Chronic bronchitis | | | |
| Congenital malformations *(birth defect)* | | | |
| Diabetes *(sugar)* | | | |
| Digestive or bowel disease | | | |
| Eczema | | | |
| Emphysema | | | |
| Epilepsy | | | |
| Glaucoma | | | |
| Gout | | | |
| Hay fever | | | |
| Heart attack | | | |
| Heart disease | | | |
| High blood pressure | | | |
| Kidney or bladder disease | | | |
| Kidney stones | | | |
| Liver or gallbladder disease | | | |
| Lung cancer | | | |
| Mental illness | | | |
| Mental retardation | | | |
| Nervous system disease | | | |
| Psoriasis | | | |

**(NOTE: This section continues at top of next page.)**

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# MEDICAL HISTORY *(Continued)*

**FAMILY HISTORY** *(Continued)*

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Sickle cell disease or trait | | | |
| Stroke | | | |
| Thyroid disease | | | |
| Tuberculosis *(T.B.)* | | | |
| Ulcer *(stomach, duodenal, peptic)* | | | |
| Other cancers or leukemia | | | |

Is your mother still living? ☐ No ☐ Yes

If not, please give age at death: ____ Years

and cause of death:

Is your father still living? ☐ No ☐ Yes

If not, please give age at death: ____ Years

and cause of death:

Are you aware of any disease or illnesses that run in your family? *(If yes, please list below):* ☐ No ☐ Yes

**IMMUNIZATIONS, VACCINES, ANTITOXINS:** If you have received any of the following, check the appropriate box(es) and give the approximate dates, if known.

| | Date *(mm/dd/yyyy)* |
|---|---|
| ☐ Tetanus | |
| ☐ Poliomelitis | |
| ☐ Influenza | |
| ☐ Typhoid | |
| ☐ Diptheria | |
| ☐ Rabies | |
| ☐ Rubella *(German measles)* | |
| ☐ Measles *(Rubeola or red measles)* | |
| ☐ BCG | |
| ☐ Yellow Fever | |
| ☐ Smallpox | |
| ☐ RhoGAM *(Rh immune globulin)* | |
| ☐ Immune serum globulin for hepatitis | |
| ☐ Others *(please list):* | |
| | |
| | |
| | |
| ☐ Mantoux, patch test, or other skin test for tuberculosis | |

**Results:** ☐ Positive ☐ Negative

**MEDICATIONS:** Have you taken any of the following medications in the last month?

| | NO | YES PAST | YES CURRENT |
|---|---|---|---|
| Antacids | | | |
| Antibiotics *(e.g., penicillin, ampicillin, tetracycline)* | | | |
| Antihistamines | | | |
| Aspirin | | | |
| Benzedrine / Dexedrine | | | |
| Birth control pills | | | |
| Blood thinners *(anti-coagulants)* | | | |
| Codeine | | | |
| Cortisone or other steroids | | | |
| Diet pills | | | |
| Digitalis or other heart pills | | | |
| Diuretic or water pills | | | |
| Hormones | | | |
| Insulin or oral anti-diabetic drugs | | | |
| Iron pills | | | |
| Laxatives | | | |
| Morphine | | | |
| Nitroglycerine | | | |
| Pain killers *(aspirin, empirin, anacin, bufferin, etc.)* | | | |
| Pep pills or Mood elevators | | | |
| Pills to lower your blood pressure | | | |
| Sleeping pills | | | |
| Sulfa preparations | | | |
| Thyroid medication | | | |
| Tranquilizers, sedatives, or nerve pills | | | |
| Vitamins | | | |
| Others | | | |

**HISTORY OF HOSPITALIZATION:** Have you ever been hospitalized?

☐ No ☐ Yes *(If yes, list reason(s) and date(s) of hospitalization.)*

Do you have any problems you would like to discuss with the doctor?

☐ No ☐ Yes *(If yes, please list them):*

SIGNATURE AND DATE COMPLETED