ATHENS LIMESTONE OCCUPATIONAL HEALTH
Comprehensive Medical & Occupational Health History Questionnaire

Employer Requesting Exam:_____

Please answer ALL questions accurately and completely.

Identification Data: Fill in the following information. PLEASE PRINT. **Today's Date:** _____/_____/_____

_____ _____/_____/_____ Age:_____
Name Birthdate (Day/Month/Year)

❑ Male ❑ Female ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

_____ _____
Home Address Employer/Dept Previously Employed here? ❑ Yes ❑ No

_____ _____
Home Telephone Occupation / Position Applied For

Your Health History: Mark an **X** in the box next to any of the following illnesses you now have or have **EVER** had.

❑ Anemia
❑ Anxiety, Depression, ADHD, ADD, Etc.
❑ Asthma
❑ Back Pain or Problems / Herniated Disc
❑ Bleeding Tendencies or Disorder
❑ Bronchitis – Frequent
❑ Carpal Tunnel Syndrome
❑ Chest Pain
❑ High Cholesterol
❑ Diabetes: Last A1C_____ Date____/____/____
❑ Emphysema
❑ Eye problems
❑ Fainting Spells
❑ Glaucoma
❑ Hand or Wrist Injury
❑ Hay Fever or Allergies
❑ Hearing Trouble
❑ Heart Attack
❑ Heart Trouble (other)
❑ Hernia(s)
❑ High Blood Pressure
❑ Hives or Rashes
❑ Kidney / Bladder Trouble
❑ Liver Disease / Hepatitis / Jaundice
❑ Narcotic use – chronic or periodic
❑ Narcotic withdrawal – previous, under treatment
❑ Trauma (Fall, Motor Vehicle Accident, etc)
❑ Pain in Hands or Feet
❑ Rheumatic Fever
❑ Neurologic Disorder – MS, Parkinsons, Other
❑ Arthritis
❑ Seizures
❑ Stroke / Mini-Stroke
❑ Tuberculosis / + TB Test
❑ Other Chronic Disorder

Medications
List below ANY medications you take on a regular AND intermittent basis, BOTH prescription AND over the counter:

Patient Name: Date:

Y	N	Have you ever been hospitalized or had surgery? If yes, list when & reason:	Y	N	Are you allergic to any medication(s) or food(s)? List below:
Y	N	Have you had a tetanus booster in the last 7 years? If yes, what year? _____	Y	N	Have you ever been off work for more than one day due to job-related illness or injury? If yes, when and what was the injury?
Y	N	Do you smoke cigarettes now? Packs per day:_____ Years:_____	Y	N	Do you use chewing tobacco or snuff? Cans per day:_____ Years:_____
Y	N	Have you smoked in the past? If yes, when did you quit?_____	Y	N	Do you drink alcohol? ___drinks per day ____per week ____ per month
Y	N	Do you use, or have you recently used: methamphetamine, cocaine, marijuana, PCP, Acid, Ecstasy, Molly, Ice, Crack? Or any Vicodin, Hydros, Morphine, Fentanyl, Xanax, Dilaudid, Klonipin, Oxycodone, Valium, Ativan that was not prescribed to you?	Y Y	N N	Have you ever been in a rehab facility for addiction treatment? If yes, Year:_____ Have you taken Methodone or Suboxone/Subutex/any form of buprenorphine within the last 3 months?
Y	N	Do you have loss of vision in either eye that cannot be corrected?	Y	N	Do you have loss of hearing that requires a hearing aid?
Y	N	Do you have decreased function, or chronic or recurring pain or tingling in either hand, including grip & strength & the use of all fingers?	Y	N	Do you have decreased function, or chronic or recurring pain, in hips, knees, legs, ankles, or feet?
Y	N	Do you have decreased function, or chronic or recurring pain, in neck or lower back?	Y	N	Have you ever had a problem with tolerating heat or had a heat-related event?
Y	N	Have you ever had a broken bone? If yes, which one(s)?:			Other:

I, the undersigned, do hereby certify that to the best of my knowledge, the answers I have given to the questions above are true and I have no impairments except as stated above. I understand that correct and complete information is necessary for the provider to make a medical decision regarding my safety in my proposed job duty, and any intentional omission or falsification of answers either verbally or in writing above may result in termination of my employment.

I hereby consent to allow the performance of breath &/or fluid testing for alcohol and/or drugs at any time during the examination process.

I understand that all information given in this questionnaire is retained in my confidential medical record. I understand that only information related to my ability to perform the essential functions of my position in a capable and safe manner will be released to my employer.

Patient Signature: _____ **Date:**_____

Reviewed by: _____ **Date:**_____

Patient Name_____ **Date:**_____

Your Exposure History: Please answer the below questions, taking into consideration any previous jobs you have had.
Please mark an **X** in either the **Yes** or **No** box following each of the items listed below.

Have you been exposed to:

	Yes	No	How Long?
1. Dust			
2. Welding & Soldering Fumes			
3. Exhaust from Engines			
4. Noise or loud music			
5. Heat			
6. Aircraft Engines			
7. Heavy Gunfire			
8. Cold			
9. Unusual Stress			

Have you ever worked with:

1. Arsenic			
2. Asbestos			
3. Benzene			
4. Beryllium			
5. Cadmium & compounds			
6. Carbon Disulfide			
7. Carbon Monoxide			
8. Carbon Tetrachloride			
9. Cement Dust			
10. Chloride			
11. Chrome compounds			
12. Cutting and Soluble Oils			
13. Epoxy Resins			
14. Fiberglass			
15. Fluorides			
16. Hydrogen Sulfide			
17. Lead			
18. Other Heavy Metals			
19. Pesticides			
20. Phenol			
21. Phosgene			
22. Radioactive Substances			
23. Solvents			
24. Paints, Glues			

Provider Comments:

Patient Signature_____ Date_____