McLeod Occupational Health

MEDICAL HISTORY FORM

Employee Name_____ **SSN** _____
Employer_____ **Job Title** _____
Sex: [ ] Male [ ] Female **Date of birth** _____

(Please us the last page if you need additional space to explain any answers)

MEDICAL CONDITION:

Have you ever had chronic or recurring pain, abnormal sensation, tingling or numbness associated with:	**Y**	**N**	***Have you ever had chronic or recurring pain, abnormal sensation, tingling or numbness associated with::***	**Y**	**N**
Neck			Arms		
Wrists			Hands		
Feet			Back		
Shoulders			Knees		

Please explain all "YES" answers:

Do you have or have you ever had:	**Y**	**N**	***Do you have or have you ever had:***	**Y**	**N**
Hearing or Vision problems			Back Problems		
Skin Problems (e.g. rash, open sores)			Muscular Disease		
Asthma			Varicose Veins		
Lung or Pulmonary Problems			Broken Bones		
Heart Condition			Automobile Accidents		
Hepatitis			Seizures, Fainting		
Diabetes			Mental Illness		
Cancer			Depression/Anxiety		
Hypertension			History of substance abuse		
HIV			Hernia		
Arthritis			Surgeries		
Head/spinal injuries			Other		

Please explain all "YES" answers:

	Y	**N**		**Y**	**N**
Are you currently under treatment or follow-up care from a doctor, chiropractor or other health care provider?			Do you need any accommodations, job modifications, and or structural changes to your work area due to a health-related condition?		

Please explain all "YES" answers:

MEDICAL HISTORY:

Please list all inpatient or outpatient admissions with date, diagnosis/injury, reason for surgery and treatment. Include childbirths, surgeries and injuries.

ALLERGIES	**Y**	**N**		**Y**	**N**
Have you ever had a reaction, allergy, and/or sensitivity to any medications, immunizations, foods, chemicals, or other?			Do you have problems when wearing gloves or has a physician ever diagnosed you with a latex allergy?		

If "Yes" - Please list medications, immunizations, foods, chemicals or other allergies.

Do you use tobacco products of any kind? [ ] Yes [ ] No If yes, describe how much:

(Females only) Is it possible you are pregnant? [ ] Yes [ ] No Due Date:_____

PLEASE LIST ALL EMPLOYMENT STARTING WITH THE MOST RECENT:		
Employer: Job Title: Dates of employment:	Job Duties: Hazards	Occupational Exposures or Injuries:
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	Y	N
Have you ever had an exposure to blood or body fluids while working on the job?		
If "Yes", please describe:		

	Y	N
Have you ever been hurt on the job while working for any employer?		
Did you ever file a **Workers Compensation Claim?** If yes, How many?_____		

*****If you answered yes to the above question, describe all your incidents & injuy (ies):*****

Date	Diagnosis/Injury	Treatment	Claim Status	Employer (where were you working for each claim)
			☐Open ☐Closed	
			☐Open ☐Closed	
			☐Open ☐Closed	

	Y	N
Are you still being treated for any of the injuries above?		
If "YES", explain any current treatment:		

	Y	N
Have you received any permanent restrictions and/or medical impairment rating from any healthcare provider?		
If "Yes", describe the details as ell as the year of the permanent restrictions and/or impairment rating:		

The preceding answers are true to the best of my knowledge. I understand that any misstatement of fact may be grounds for termination of my employment. Misstatement of facts could result in my not receiving benefits for any injury or illness sustained on the job. I under stand the information related to this medical history and evaluation will become part of my medical record, and may be used to determine my capability to perform essential functions of the job (with or without accommodations.) I further understand that information gained from this medical history and evaluation may be shared with my employer in determining medical clearance for job placement, job restrictions, or need for accommodations.

_____ _____ _____ _____

Patient Signature Date Examining Nurse Date

Additional Notes and/or Explanations:

_____
_____
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