McLeod Occupational Health
The Choice for Medical Excellence.

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?	☐	☐
Have you received any permanent restrictions and/or medical impairment rating from any healthcare provider?	☐	☐	Do you use tobacco products of any kind?	☐	☐
			(Females) Is it possible you are pregnant? Due date:_____	☐	☐

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.

_____

Current Medications:_____ _____ _____

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.

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: