

## Health History

### Personal Information

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Personal Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Ethnic Origin

\_\_\_\_\_ Caucasian \_\_\_\_\_ Black \_\_\_\_\_ Hispanic  
\_\_\_\_\_ Asian / S. Pacific Islander \_\_\_\_\_ American Indian \_\_\_\_\_ Other : \_\_\_\_\_

**Allergies** (check where appropriate)  No known medication allergies  
 No known food allergies

List medication allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe reaction: \_\_\_\_\_

List food allergies: \_\_\_\_\_  
\_\_\_\_\_

Describe reaction: \_\_\_\_\_

Other: \_\_\_\_\_

Describe reaction: \_\_\_\_\_

### Current Medications / Herbal Supplements / Vitamins

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason for Use</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Vaccinations (list year or date of last vaccination, mark 'no' if you have not received)

Tetanus: \_\_\_\_\_ Hepatitis A: \_\_\_\_\_ Hepatitis B: \_\_\_\_\_

MMR: \_\_\_\_\_ Varicella: \_\_\_\_\_

Have you ever had chicken pox?  Yes  No

**Other Information**

Are you currently under a doctor's care?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you have any physical limitations or permanent restrictions?  Yes  No

If yes, please explain: \_\_\_\_\_

(Written documentation from your health care provider will be required)

**Mark any of the following that you use:**  None

Glasses  Contacts  Hearing aid  Pace maker

Artificial limb  Crutches  Wheel chair

Other (Describe) \_\_\_\_\_

**Tobacco Use**

Never  Quit When? \_\_\_\_\_ Number of years smoked \_\_\_\_\_

Cigarettes  Cigars Number per day \_\_\_\_\_

Pipe Times per day \_\_\_\_\_  Smokeless Tobacco Times per day \_\_\_\_\_

**Alcohol Use**

None  Occasionally Amount of alcoholic drinks per week \_\_\_\_\_

**Personal Health History.** Please check the boxes of any of the listed conditions that you currently have or have had in the past. Use the space at the bottom of each question to list any complications, procedures, hospitalizations or operations associated with the condition.

**Autoimmune**

None

Arthritis  Lupus Age diagnosed: \_\_\_\_\_  Reynauds disease

Comments: \_\_\_\_\_

**Cancer**

Yes  No

If yes, explain type of cancer and treatment: \_\_\_\_\_

**Emotional**

None

Anxiety  Depression  Bipolar Disorder  Other: \_\_\_\_\_

Comments: \_\_\_\_\_

**Endocrine**

None

Diabetes: Taking pills \_\_\_\_\_ Insulin shots \_\_\_\_\_ Insulin pump \_\_\_\_\_ Diet controlled \_\_\_\_\_

Thyroid Disease: Underactive \_\_\_\_\_ Overactive \_\_\_\_\_

Comments: \_\_\_\_\_

**Eye, Ear, Nose and Throat**  None

Blindness: Right eye \_\_\_\_\_ Left eye \_\_\_\_\_ Color blindness \_\_\_\_\_

Cataracts  Glaucoma

Ear disorders  Decreased hearing: Right ear \_\_\_\_\_ Left ear \_\_\_\_\_

Sinus problems

Comments: \_\_\_\_\_

**Females Only**

Last menstrual period: \_\_\_\_\_ Are your periods regular?  Yes  No

Do your periods significantly interfere with your daily activities?  Yes  No

If yes, how? \_\_\_\_\_

Ovarian cysts  Endometriosis

Last mammogram: \_\_\_\_\_ Last PAP smear: \_\_\_\_\_

Comments: \_\_\_\_\_

**Gastrointestinal**  None

Colitis  Frequent indigestion  Hepatitis or liver disorder  
 Hernia  Hemorrhoids  Ulcers  Unexplained weight loss

Comments: \_\_\_\_\_

**Genitourinary**  None

Blood in urine  Frequent bladder or kidney infections  Kidney disease  
 Kidney stones  Prostate problems (males only)

Comments: \_\_\_\_\_

**Head**  None

Epilepsy  Frequent headaches  Head injury  Migraines

Comments: \_\_\_\_\_

**Heart and Lung**  None

Angioplasty or heart bypass surgery  Ankle swelling  Asthma  
 Blood or bleeding problems  Chest pain or pressure  Chronic bronchitis  
 Chronic cough  Collapsed lungs  Emphysema  
 Heart attack  High blood pressure  High cholesterol level  
 Irregular heart beat  Phlebitis  Pneumonia  
 Rib fractures  Tuberculosis  Varicose veins

Comments: \_\_\_\_\_

**Musculoskeletal**  None

Bone fractures  Back problems  Carpal tunnel syndrome  
 Ganglion cyst  Muscle weakness

Comments: \_\_\_\_\_

**Skin**  None

Rashes  Sores

Comments: \_\_\_\_\_

<b>Surgical History</b>	<u>Type of procedure</u>	<u>Date performed</u>

### Family History

Place a check if any family members currently have or have had in the past any of the following conditions. Place a 'D' if the condition was the cause of death.

	Mother	Father	Sister	Brother
Alcohol dependency				
Arthritis				
High blood pressure				
Heart attack				
Stroke				
Diabetes				
Lung disease				
Tuberculosis				
Cancer				
Epilepsy				
Mental disorder				
Obesity				

Comments: \_\_\_\_\_

### Work History

Place a check by any of the following you have had contact with in the past. Underline any which you presently are exposed to (at work or home).

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Acids                       | <input type="checkbox"/> Chloroform         | <input type="checkbox"/> Ketones            | <input type="checkbox"/> Rock dust                        |
| <input type="checkbox"/> Alcohol (industrials)       | <input type="checkbox"/> Chloroprene        | <input type="checkbox"/> Lead               | <input type="checkbox"/> Silica dust                      |
| <input type="checkbox"/> Alkalis                     | <input type="checkbox"/> Chromates          | <input type="checkbox"/> Manganese          | <input type="checkbox"/> Solvents                         |
| <input type="checkbox"/> Ammonia                     | <input type="checkbox"/> Coal Dust          | <input type="checkbox"/> Mercury            | <input type="checkbox"/> Styrene                          |
| <input type="checkbox"/> Asbestos                    | <input type="checkbox"/> Cold (severe)      | <input type="checkbox"/> Methylene Chloride | <input type="checkbox"/> Talc                             |
| <input type="checkbox"/> Arsenic                     | <input type="checkbox"/> Cotton dust        | <input type="checkbox"/> Nickel             | <input type="checkbox"/> Tolulene                         |
| <input type="checkbox"/> Benzene                     | <input type="checkbox"/> Dichlorobenzene    | <input type="checkbox"/> Noise              | <input type="checkbox"/> TDI or MDI                       |
| <input type="checkbox"/> Beryllium                   | <input type="checkbox"/> Ethylene Dibromide | <input type="checkbox"/> PCBs               | <input type="checkbox"/> Trichloroethylene                |
| <input type="checkbox"/> Cadmium                     | <input type="checkbox"/> Ethylene Oxide     | <input type="checkbox"/> Perchlorethylene   | <input type="checkbox"/> Trinitrotolulene                 |
| <input type="checkbox"/> Carbon<br>Tetrachloride     | <input type="checkbox"/> Fiber Glass        | <input type="checkbox"/> Pesticides         | <input type="checkbox"/> Vibration / repetitive<br>motion |
| <input type="checkbox"/> Chlorinated<br>Naphthalines | <input type="checkbox"/> Formaldehyde       | <input type="checkbox"/> Phenol             | <input type="checkbox"/> Vinyl chloride                   |
|  | <input type="checkbox"/> Heat (severe)      | <input type="checkbox"/> Phosgene           | <input type="checkbox"/> Welding fumes                    |
|  | <input type="checkbox"/> Isocyanates        | <input type="checkbox"/> Radiation          | <input type="checkbox"/> X-rays                           |

Comments: \_\_\_\_\_

### Protective Equipment Currently Being Used

- |   |  |                                   |   |
|---|--|-----------------------------------|---|
| <input type="checkbox"/> Apron          | <input type="checkbox"/> Face mask         | <input type="checkbox"/> Gloves   | <input type="checkbox"/> Respirator       |
| <input type="checkbox"/> Ear protection | <input type="checkbox"/> Glasses / goggles | <input type="checkbox"/> Hard hat | <input type="checkbox"/> Steel-toed shoes |
- Personal protective equipment:  Seat belt  Ear protection

Comments: \_\_\_\_\_

### Leisure Time Activities

- |                                      |                                   |                                      |                                       |   |
|--------------------------------------|-----------------------------------|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Auto repair | <input type="checkbox"/> Biking   | <input type="checkbox"/> Gardening   | <input type="checkbox"/> Racquetball  | <input type="checkbox"/> Walking        |
| <input type="checkbox"/> Auto racing | <input type="checkbox"/> Boating  | <input type="checkbox"/> Hunting     | <input type="checkbox"/> Running      | <input type="checkbox"/> Water skiing   |
| <input type="checkbox"/> Baseball    | <input type="checkbox"/> Ceramics | <input type="checkbox"/> Motorcycles | <input type="checkbox"/> Scuba diving | <input type="checkbox"/> Weight lifting |
| <input type="checkbox"/> Basketball  | <input type="checkbox"/> Fishing  | <input type="checkbox"/> Needlework  | <input type="checkbox"/> Snow skiing  | <input type="checkbox"/> Woodworking    |
| <input type="checkbox"/> Other _____ |                                   |                                      |                                       |   |

**Educational Needs / Religious & Cultural Needs**

In order for the nurse to provide effective care, please complete the following:

Learns best by:  Reading  Pictures / Video  Practice  Explanation

I have a problem with reading or writing?  Yes  No

I have special religious or cultural needs?  Yes  No

My primary language is:  English  Spanish  Japanese  Other: \_\_\_\_\_

**Advance Directive**

Do you currently have an Advance Directive?

Advance Care Plan

Appointment of Healthcare Agent

Physician Order for Scope of Treatment (POST)

Would you like more information about advance directives?  Yes  No

**Release of Information and Consent for Treatment**

In order to provide a safe and healthy working environment, member(s) of \_\_\_\_\_  
Company

personnel will be informed on a need to know basis, of any medical history or current medical condition, which may:

- 1. put that individual or coworkers at risk.
- 2. be necessary to make job assignments in accordance with work restrictions or limitations.
- 3. be necessary to provide on-site medical care or treatment.

I hereby give permission for the Business Health Nurse to render first aid or any treatment covered under the Blount Memorial Business Health Medical Directives or Medical Director orders. I understand that it is my responsibility to obtain any further evaluation that may be needed.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Medical Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_