CORPORATE CARE
OCCUPATIONAL MEDICINE
MEDICAL SURVEILLANCE QUESTIONNAIRE:
PERIODIC EVALUATION:

Date: _____

Name: _____ Date of Birth: _____

Social Security No. _____

Title of Position: _____ Department: _____

Telephone: home _____ Work _____

The purpose of this questionnaire is to gather information concerning your present and past health and physical condition, since your last medical surveillance exam. This information will be used to determine whether you can safely perform the duties of the job you are performing, or suffering any ill effects from this work.

Answer all of the questions completely. Your answers will be confidential and will be released only to authorized personnel. If you have any questions, please ask the doctor who will examine you or the appropriate representatives of your employer.

If you answer "yes" in any of the areas, please provide details such as dates, drugs taken, treatment, or other information which may be important. In addition, if you are unsure of your answer to any question, answer it "yes" and provide an explanation in the appropriate section.

PLEASE ANSWER EACH OF THE QUESTIONS IN THIS QUESTIONNAIRE HONESTLY, AS THE ACCURATE COMPLETION OF THIS FORM IS VITAL FOR ASSESSING ANY POSSIBLE ILL EFFECTS RESULTING FROM YOUR WORK.

Date of last physical examination _____ Have you seen a physician since your last exam? _____
Why? (list injuries or illness) _____
_____

I. List below all medications or injections taken regularly in the past or at the present. If none, write in "none"

Date	Name of Medication	Reason for using medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE READ!!!!!!

IF YOUR LAST MEDICAL SURVEILLANCE EXAMINATION WAS PERFORMED HERE (WITHIN THE PAST YEAR), AND NO CHANGES HAVE OCCURRED WITH YOUR HEALTH, PLEASE CHECK HERE ( ). IF THIS IS SO, YOU NEED NOT COMPLETE THE REST OF THE FORM, BUT PLEASE SIGN THE LAST PAGE. IF ANY CHANGES HAVE OCCURRED, CHECK HERE ( ) AND CONTINUE.

II. PAST HISTORY: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section.

Yes	No	Have you ever had any of the following:	Yes	No	
( )	( )	1. Allergies (medicine, pollen, etc)	( )	( )	12. Heart murmur
( )	( )	2. Arthritis	( )	( )	13. Hormone Treatments
( )	( )	3. Asthma	( )	( )	14. Kidney disease
( )	( )	4. Bleeding tendency	( )	( )	15. Liver disease
( )	( )	5. Blood disease	( )	( )	16. Medicine to thin blood
( )	( )	6. High blood pressure	( )	( )	17. Epilepsy or seizure disorder
( )	( )	7. Chronic blood or lymph condition such as leukemia, Hodgkin's disease or hemophilia	( )	( )	18. Stroke
			( )	( )	19. Tumor, growth or cyst
			( )	( )	20. Hayfever
( )	( )	8. Cancer			
( )	( )	9. Anemia			
( )	( )	10. Depression			
( )	( )	11. Diabetes			

Explain "yes" answers from section II. (include item No.)

_____

_____

III. GENERAL HISTORY: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Have you ever?
( )	( )	1. Consumed alcohol? If yes, how much per week? Beer_____ Wine_____ Hard liquor _____
( )	( )	2. Smoked? If so, how much per day? Cigarettes_____ Pipe_____ Cigar _____ How many years?_____

IV. OCCUPATIONAL HISTORY: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Have you ever?
( )	( )	1. Had a job related illness?
( )	( )	2. Lost time from work because of a job related illness? Number of work days missed _____ .
( )	( )	3. Left a job or changed occupations because of your health?
( )	( )	4. Had any health problem which you think was caused by substances with which you worked?
( )	( )	5. Been told a doctor or other health care practitioner to permanently or temporarily omit or restrict your work activity?

Yes	No	
( )	( )	6. Made a claim for a job illness? Was it paid? Yes_____ No_____
( )	( )	7. Received a temporary or permanent disability award or pension for a job illness?
( )	( )	8. Filed a job injury claim that is still open and pending?

Explain "Yes" answers from section IV. (include item No.)

_____

_____

V. NERVOUS SYSTEM: Answer "Yes" or "No" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you now or have you had?
( )	( )	1. Severe headache(s) or migraines?
( )	( )	2. Light headedness, dizziness, or vertigo?
( )	( )	3. Blackouts, seizures, or convulsions?
( )	( )	4. Memory problems?
( )	( )	5. Tingling ("pins and needles") feeling in your legs, arms, face, or body?
( )	( )	6. Numbness (no, or partial feeling) in your legs, arms, face, or body?
( )	( )	7. Muscle weakness in your legs, arms, or face?
( )	( )	8. Trouble dropping things, or clumsiness?
( )	( )	9. Recent mood changes, personality changes, noted by you or others?
( )	( )	10. Fatigue, tiredness, or decrease in your ability to stay alert?

Explain "yes"answers from section V. (include item No.)

_____

_____

VI. HEART & LUNGS: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you have or have you ever had:
( )	( )	1. An irregular heart beat?
( )	( )	2. Chest pain or angina?
( )	( )	3. Heart disease?
( )	( )	4. A heart attack or myocardial infarction?
( )	( )	5. Rheumatic fever or vascular heart disease?
( )	( )	6. High blood pressure or hypertension?
( )	( )	7. Increasing shortness of breath upon mild exertion (climbing stairs, etc)?
( )	( )	8. Chronic cough or bronchitis?
( )	( )	9. Emphysema?
( )	( )	10. Pneumonia?
( )	( )	11. Asthma?

Explain "yes" answers from section VI. (include item No.)

_____

_____

VII. GASTRO-INTESTINAL SYSTEM: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you or have you ever had:
( )	( )	1. Peptic ulcer disease?
( )	( )	2. Recurrent indigestion or stomach pain?
( )	( )	3. Gallstones?
( )	( )	4. Yellow jaundice or hepatitis?
( )	( )	5. Blood in your stools or black stools?
( )	( )	6. Recurrent diarrhea?
( )	( )	7. Prolonged constipation?
( )	( )	8. Hemorrhoids?
( )	( )	9. Colitis?

Explain "yes" answers from section VII: (include item No.)

_____

_____

VIIIA. GENITO-URINARY SYSTEM: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you have or have you ever had:
( )	( )	1. Difficulty urinating or pain upon urinating?
( )	( )	2. Urine control problems?
( )	( )	3. Pus or blood in urine?
( )	( )	4. Kidney stones?
( )	( )	5. Kidney infection?
( )	( )	6. Bladder infection?
( )	( )	7. Protein in your urine?

VIIIB. REPRODUCTIVE SYSTEM: Please respond to the following for *yourself and spouse*.
Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

SELF	SPOUSE	Do you have or have you ever had:
_____	_____	1. History of miscarriages?
_____	_____	2. History of reproductive problems?/Infertility?/Difficulty conceiving?
_____	_____	3. Any children with congenital abnormalities?/Learning difficulties?
_____	_____	4. Impotence?
_____	_____	5. Premature births?
_____	_____	6. Abnormal menstrual periods?
_____	_____	7. History of still births?

Explain "yes" answers from section VIIA & B: (include item No)

_____

_____

IX. ENDOCRINE SYSTEM: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you have or have you ever had:
( )	( )	1. Thyroid problems?
( )	( )	2. Persistently swollen lymph nodes?

Explain "yes" answers from section IX. (include item No.)

_____

X. EYE: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you have or have you ever had:
( )	( )	1. Difficulty seeing distant objects?
( )	( )	2. Difficulty seeing close objects?
( )	( )	3. Color blindness?
( )	( )	4. Cataract(s)?
( )	( )	5. Glaucoma?
( )	( )	6. Radial Keratotomy?
( )	( )	7. Orthokeratology?
( )	( )	8. Loss of vision?
( )	( )	9. A reduction(s) in your visual fields (ability to see up, down, or left or right)?
( )	( )	10. Glasses?
( )	( )	11. Contact lenses?
( )	( )	12. Recurrent eye burning, itching or tearing, particularly while at work?

Explain "yes" answers from section X: (include item number).

_____

_____

XI. EAR: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you have or have you ever had:
( )	( )	1. Ringing in your ears?
( )	( )	2. Diminished hearing?
( )	( )	3. Ear tubes?
( )	( )	4. Recurrent ear infection?
( )	( )	5. A hearing aid or been recommended to use a hearing aid?
( )	( )	6. Exposure to prolonged loud noises?

Explain "yes" answers to from section XI: (include item No.)

_____

_____

XII. NOSE AND THROAT: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you have or have you ever had:
( )	( )	1. Chronic nasal or sinus congestion?
( )	( )	2. Loss of smell?
( )	( )	3. Difficulty swallowing?
( )	( )	4. Recurrent hoarseness or loss of your voice?
( )	( )	5. Recurrent sore or burning throat?
( )	( )	6. Increased saliva (spit) or drooling?
( )	( )	7. Runny nose?

Explain "yes" answers from section XII: (include item No.).

_____

_____

XIII. SKIN: Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you have or have you ever had:
( )	( )	1. Skin cancer or sun related lesions?
( )	( )	2. Rash, dryness, or cracking of your palms or feet?
( )	( )	3. Allergic dermatitis (skin allergy to a chemical or other)?
( )	( )	4. Irritant dermatitis (skin rash, itching, or irritation after use of a chemical)?
( )	( )	5. Skin rashes that require a doctor's evaluation?
( )	( )	6. Ulcers or holes in the skin?
( )	( )	7. Itching while at work?
( )	( )	8. Itching while not at work?

Explain "yes" answers from section XIII: (include item No.)

_____

_____

XIV. FAMILY HISTORY:

Do any illnesses or conditions "run" in your family?: (if no changes have occurred in this section since your last exam, check here ( ) and go on to the next section):

Do any direct relatives (siblings, parents, aunts, uncles or grandparent) suffer from (and if yes, who, and at what age?):

Yes	No	Who	Age	
( )	( )	____	____	1. Heart disease
( )	( )	____	____	2. Stroke
( )	( )	____	____	3. Eczema

Yes	No	Who	Age	
( )	( )	____	____	4. Colitis
( )	( )	____	____	5. Rashes
( )	( )	____	____	6. Asthma
( )	( )	____	____	7. Hay fever or allergies
( )	( )	____	____	8. Thyroid disease

XVA. OCCUPATIONAL / ENVIRONMENTAL HISTORY FORM

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing) ? If yes, please check the box beside the name. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

( ) Alcohols (industrial)	**( ) Diisochlorobenzene**	**( ) PCBs**	**( ) Trichloroethylene**
( ) Alkalis	**( ) Ethylene dibromide**	**( ) Perchloroethylene**	**( ) Trinitrotoluene**
( ) Ammonia	**( ) Ethylene dichloride**	**( ) Pesticides**	**( ) Vinyl chloride**
( ) Arsenic	**( ) Fiberglass**	**( ) Phenol**	**( ) Welding Fumes**
( ) Asbestos	**( ) Halothane**	**( ) Phosgene**	**( ) X-ray**
( ) Benzene	**( ) Isocyanates**	**( ) Radiation**	**( ) Other (specify)**
( ) Beryllium	**( ) Ketones**	**( ) Rock dust**	
( ) Cadmium	**( ) Lead**	**( ) Silica powder**	
( ) Carbon tetrachloride	**( ) Manganese**	**( ) Solvents**	
( ) chlorinated naphthalenes	**( ) Mercury**	**( ) Styrene**	
( ) Chloroform	**( ) Methylene chloride**	**( ) Talc**	
( ) Chromates	**( ) Nickel**	**( ) Toluene**	
( ) Coal dust	**( ) PBBs**	**( ) TDI or MDI**	

XVB. OCCUPATIONAL PROFILE

Fill in the table below listing all jobs at which you have worked, including short-term, seasonal, and part-time employment. Start with your present job and go back to the first. Use additional paper if necessary. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Workplace Employer's name	Dates worked From To	Did you work fulltime?	Type of Job (describe)	Known health hazards in workplace	Protective equipment used

XVC: CURRENT WORK DESCRIPTION:

Please fill in the following to give us an idea of your current work environment. (If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section):

1. Hours worked per day: _____ **hrs/day.**

2. Days worked per week: _____ **days/week.**

3. Actual days worked: _____ **Mon-Fri.**

_____ Other (please circle days usually worked: Mon Tues Wed Thurs Fri Sat Sun)

4. Overtime: _____ **Yes** _____ **No**

5. Job title: _____

6. Years worked at current job: _____

7. Location in plant/warehouse/jobsite where you usually work: _____

8. Number of hours per day spent working with chemicals: _____

9. Number of hours per day spent wearing a respirator: _____

10. Number of hours per day spent working with metals: _____

11. Type of respirator used: _____

12. Names/types of chemicals/metals/dusts/fumes/mists/vapors that you come into contact with at work:

_____

13. Describe your usual level of work activity(check one):

_ Sedentary
_ Light (very light work, such as filing, occasional walking, but not enough to "work up a sweat")
_ Moderate (some exertion, such as lifting, pushing/pulling, bending, rapid pulse)
_ Heavy(hard, exertional work)

14. Describe the work environment of your job(check as many as apply):

_ Temperature controlled (usually comfortable, around 72 degrees)
_ Occasional (indoor) variations (occasionally cold)
_ Occasional (indoor) variations (occasionally hot)
_ Occasional outdoor work
_ Occasional changes in humidity

15. Work exposure concerns that you may have (what do you think that you should be protected from at work?):

XVI. ORTHOPEDIC HISTORY:

Answer "yes" or "no" to the following questions. If no changes have occurred in this section since your last exam, check here ( ) and go on to the next section:

Yes	No	Do you have or have you ever had:
( )	( )	**1. Any conditions which limit you from performing certain body movements or assuming body positions such as bending, lifting, stooping, or squatting with or without pain?**
( )	( )	**2. Weakness or loss of use of any part of your body?**
( )	( )	**3. Any leg, knee or foot problems that interfere with standing or walking?**
( )	( )	**4. Broken bone(s)?**
( )	( )	**5. Any condition that limits moving your joints fully?**
( )	( )	**6. Dislocated joint(s)?**
( )	( )	**7. Cortisone injections for any of your joints?**
( )	( )	**8. Neck pain or injury?**
( )	( )	**9. Back pain?**
( )	( )	**10. Back injury?**
( )	( )	**11. Back discomfort during or after lifting, bending, twisting or stooping?**
( )	( )	**12. Disk problems or herniated disc?**
( )	( )	**13. Sciatica?**
( )	( )	**14. Pain which travels down your leg?**
( )	( )	**15. Knee pain, discomfort or injury?**
( )	( )	**16. Locking or giving way of your knee?**
( )	( )	**17. A swollen knee?**
( )	( )	**18. To stop exercising or jogging because of persistant pain in your knee(s)?**
( )	( )	**19. Torn or strained ligaments?**
( )	( )	**20. A swollen ankle?**
( )	( )	**21. A sore shoulder, elbow or tennis elbow that lasted longer than one week?**
( )	( )	**22. Persistant pain in either of your wirst or forearms?**
( )	( )	**23. Carpal tunnel syndrome?**
( )	( )	**24. Numbness or night time tingling in your hands or following forceful use of your wrist?**
( )	( )	**25. Been seen by, consulted with, or treated by a physician, chiropractor, physical therapist or other health care practitioner for any of the above conditions?**
( )	( )	**26. Had repeat visits with a chiropractor or other health care professional for manipulations or adjustments?**

( ) ( ) 27. Had back x-rays, CT scan, or other special test of your back (i.e. MRI)?
( ) ( ) 28. Taken any medications for any of the conditions listed above?

Explain "yes" answers from section XVI.(include item No.)

_____

_____

IX. Since your last exam, do you have any health conditions, problems, injuries, symptoms, concerns, limitations or treatments related to your work and not covered in this form? Please explain below. Also list any questions you were not sure about or did not understand. If none, write "none".

_____

_____

_____

X. Since your last exam, have you consulted with a physician or other health care professional for any health conditions related to work and not covered by this form? Please explain below. If none, write "none".

_____

_____

Please go back over this form and recheck for accuracy and completeness.
THANK YOU.

Signature: _____