MEDICAL RECORD

REPORT OF MEDICAL HISTORY

Form A – Complete History for Pre-Hire or Job Transfer

☐ Pre-Hire
☐ Job Transfer

PERSONAL INFORMATION

Last name, First name, Middle Initial	Social Security Number	Today's date	
Home Address	City	State	Zip Code

Date of Birth	Age	Sex: ☐ Male ☐ Female	Home Phone Number ( )

EMERGENCY CONTACT INFORMATION

Primary Contact Name	Relationship	Daytime phone or pager #	Evening phone or pager #
Alternate Contact Name	Relationship	Daytime phone or pager #	Evening phone or pager #

Personal physician or Primary care provider (PCP) name	City your Physician or PCP is located in	Physician or PCP phone number ( )

ALLERGIES

YES	NO	ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? If "yes" please list.
☐	☐	Any Medicine (Prescription or over-the-counter) or supplement?
☐	☐	Bee Stings or insect bites?
☐	☐	Other (Foods, grasses, etc.)?

CURRENT MEDICATIONS

LIST ALL MEDICATION YOU TAKE ON A REGULAR BASIS. Please include over-the-counter medicines, birth control pills, vitamins, herbal and other supplements. You may provide a separate list if necessary.

NAME OF MEDICATION (generic or brand name)	DOSAGE AND FREQUENCY (e.g. 10 mg once a day, etc.)	TAKEN FOR (e.g. diabetes, allergies, blood pressure, etc.)

HEALTH CONCERNS

YES	NO	PLEASE ANSWER THE FOLLOWING QUESTIONS
☐	☐	Are there any health issues or test results that you would like to discuss with the health care provider?
☐	☐	Are there any current problems at work or at home that you would like to discuss with the health care provider?

NAME:

OCCUPATIONAL HISTORY

What position are you applying for?

PROVIDE INFORMATION ON PREVIOUS 3 JOBS OR LAST 10 YEARS (whichever is longest)

1	Employer	Dates Worked
Type of Industry		Average Hours/Week
Brief Description of Job Duties		

2	Employer	Dates Worked
Type of Industry		Average Hours/Week
Brief Description of Job Duties		

3	Employer	Dates Worked
Type of Industry		Average Hours/Week
Brief Description of Job Duties		

4	Employer	Dates Worked
Type of Industry		Average Hours/Week
Brief Description of Job Duties		

If you have had more than 4 employers in the last 10 years, please list the rest of your employment history for the last 10 years.

If not, initial here: ______________

PAST OCCUPATIONAL EXPOSURES (Potential or Actual)

HAVE YOU EVER WORKED FOR AT LEAST 6 MONTHS WITH ANY OF THE FOLLOWING?

YES	NO		YES	NO	
☐	☐	Asbestos	☐	☐	Carcinogens
☐	☐	Lead	☐	☐	Blood, Body Tissues, or Body Fluids
☐	☐	Explosives	☐	☐	Micro-organisms
☐	☐	Firearms	☐	☐	Noise (In Hearing Conservation Program)
☐	☐	Hazardous Waste	☐	☐	Ionizing Radiation
☐	☐	Pesticides	☐	☐	Silica Dusts
☐	☐	Solvents	☐	☐	Other Mineral Dusts
☐	☐	Any other work-related health hazards to which you were or might have been exposed to that are not listed above. If “yes”, please list here:			

NAME:

OCCUPATIONAL MEDICAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS – Explain/describe all "yes" answers in the space to the right

YES	NO		
☐	☐	Do you have any heart, lung, or circulatory system conditions caused by your work?	
☐	☐	Do you have any health problems or injuries caused by or connected with present or past jobs?	
☐	☐	Has any doctor given you permanent work restrictions for any condition?	
YES	**NO**	HAVE YOU EVER . . .	
☐	☐	Been refused employment or been unable to hold a job because of any other medical reason?	
☐	☐	Been denied life insurance?	
☐	☐	Been rejected for or discharged from military service because of physical, mental, or other reasons?	
☐	☐	Received or applied for **ANY** V.A. disability? If yes, please describe in comments the total and breakdown of % disability ratings.	V.A. Total disability rating: __________ % Year rated:______________
☐	☐	Been off work because of a work-related injury or illness?	
☐	☐	Changed jobs or work assignments (permanently) because of a work-related illness or injury?	
☐	☐	Worked at a job which caused you trouble breathing (e.g. cough, shortness of breath, wheezing)?	
☐	☐	Had low back pain treated by a doctor or that caused you to lose time from work?	
☐	☐	Had an injury or condition of your back, which caused pain, discomfort, numbness, or tingling in your legs or feet?	
☐	☐	Had neck, shoulder, arm, elbow, forearm, wrist or hand pain that was associated with numbness or tingling, treated by a doctor, or caused you to lose time from work?	

GENERAL MEDICAL HISTORY

HOW WOULD YOU RATE YOUR OVERALL HEALTH? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

YES	NO	HAVE YOU EVER . . .	Explain/describe all "yes" answers in the space to the right
☐	☐	Been hospitalized (excluding emergency room only visits)?	
☐	☐	Been involved in any accident or had any serious injuries that required treatment?	
☐	☐	Had any neurological condition (including stroke, seizures) or any condition (such as head injury) that caused a sudden change in your behavior or your level of consciousness?	
☐	☐	Had any surgical operations? If "yes", please list – attach additional sheets if needed.	

Date or Age	Type of surgery	List any residual problems or impairment after surgery

YES	NO	
☐	☐	Do you have to stop or do you become significantly short of breath when you climb a flight of stairs? If "yes", how far can you walk on level ground before becoming short of breath?
☐	☐	Do you ever wake up at night feeling short of breath or do you need to sleep with multiple pillows in order to not feel this way? If "yes", how many pillows do you need to use?
☐	☐	Have you recently gained or lost weight unintentionally?
☐	☐	Do you wear a hearing aid?
☐	☐	Do you have any bone, joint, muscle, or nervous system conditions (including plate, pin or rod in any bone)? If "yes", do you have any limitations as a result? ☐ No ☐ Yes (please list limitations)

NAME:

GENERAL MEDICAL HISTORY – continued

DO YOU HAVE, OR HAVE YOU EVER HAD . . .

YES in the past year	**YES** > 1 yr. Ago	**NO**	**Explain/describe all "yes" answers in the space to the right**	
☐	☐	☐	High blood pressure?	
☐	☐	☐	Diabetes – If "yes", for how long?	
☐	☐	☐	Pain or pressure in your chest?	
☐	☐	☐	Palpitations or pounding heart?	
☐	☐	☐	Ulcers, heartburn or gastritis?	
☐	☐	☐	Chronic or frequently recurrent constipation, diarrhea, or both?	
☐	☐	☐	Black or tarry stools (bowel movements)?	
☐	☐	☐	Hemorrhoids or rectal bleeding?	
☐	☐	☐	Hepatitis or jaundice?	
☐	☐	☐	Gallbladder or pancreas trouble?	
☐	☐	☐	Other stomach, intestinal or liver trouble?	
☐	☐	☐	Any type of hernia?	
☐	☐	☐	Goiter, thyroid condition or pituitary condition?	
☐	☐	☐	Lumps or enlarged glands?	
☐	☐	☐	Cancer?	
☐	☐	☐	Bladder, kidney, prostate, or other urinary tract problems?	
☐	☐	☐	Blood in your urine or kidney stones?	
☐	☐	☐	Frequent or painful urination?	
☐	☐	☐	Numbness, tingling, tremors, twitching, paralysis, muscle or nerve troubles – Not previously mentioned?	
☐	☐	☐	Tuberculosis or positive TB skin test If "yes": Did you have a Chest x-ray? ☐ Yes ☐ No Did you take medicine for it? ☐ Yes ☐ No	
☐	☐	☐	Frequent or severe headaches?	
☐	☐	☐	Depression, anxiety, or other mental illness or treatment?	
☐	☐	☐	Thoughts of, or attempted suicide?	

HEALTH MAINTENANCE

WHEN WAS THE LAST TIME YOU HAD A/AN. . .

Complete physical examination with your primary care provider?	☐ Within 12 mo.	☐ 12 – 24 mo.	☐ More than 2 yr.	☐ Never
Eye exam by an optometrist or ophthalmologist?	☐ Within 12 mo.	☐ 12 – 24 mo.	☐ More than 2 yr.	☐ Never
Dental exam?	☐ Within 6 mo.	☐ 6-12 mo.	☐ More than 1 yr.	☐ Never
Electrocardiogram (EKG)?	☐ Within 12 mo.	☐ 12 – 24 mo.	☐ More than 2 yr.	☐ Never
Cardiac stress test?	☐ Within 12 mo.	☐ 12 – 24 mo.	☐ More than 2 yr.	☐ Never
Tetanus shot?	☐ Within 5 yr.	☐ 5-10 yr.	☐ More than 10 yr.	☐ Never
Skin test for Tuberculosis?	☐ Within 12 mo.	☐ 12 – 24 mo.	☐ More than 2 yr.	☐ Never
Prostate/Rectal exam (men only)?	☐ Within 12 mo.	☐ 12 – 24 mo.	☐ More than 2 yr.	☐ Never
Pap smear/Pelvic exam (women only)?	☐ Within 12 mo.	☐ 12 – 36 mo.	☐ More than 3 yr.	☐ Never
Mammogram (women only)?	☐ Within 12 mo.	☐ 12 – 24 mo.	☐ More than 2 yr.	☐ Never

HEALTH BEHAVIORS / HABITS

How much alcohol do you drink (on the average)? *1 drink = 12 oz of beer or 5 oz of wine or 1 1/2 oz hard liquor*

☐ None or less than 4 drinks/month ☐ 1-6 drinks/week ☐ 7-14 drinks/week ☐ More than 14 drinks/week

YES	NO	
☐	☐	Have you ever felt you ought to cut down on your drinking?
☐	☐	Have people annoyed you by criticizing your drinking?
☐	☐	Have you ever felt bad or guilty about your drinking?
☐	☐	Have you ever had an "eye opener" drink first thing in the morning to steady your nerves or to get rid of a hangover?

NAME:

HEALTH BEHAVIORS/HABITS – continued

YES	NO	
☐	☐	Do you smoke cigarettes? If "yes": How many packs per day? ________ For how many years? _________ Do you plan to quit? ☐ Yes ☐ No Have you tried to quit before? ☐ Yes ☐ No
☐	☐	Do you use any other tobacco product (cigars, smokeless tobacco, etc.)? If "yes": How much? ___________________ For how many years? _________ Do you plan to quit? ☐ Yes ☐ No Have you tried to quit before? ☐ Yes ☐ No
☐	☐	Have you felt your stress level was unmanageable at any time in the last year? If "yes": How often? ___________________

Please indicate how often you eat fruits and vegetables.
☐Several times a day ☐Daily ☐A few times a week ☐Once a week ☐Rarely or never

Please indicate how often you eat high fat foods.
☐Several times a day ☐Daily ☐A few times a week ☐Once a week ☐Rarely or never

Please indicate how often you exercise (not including your regular work).
☐Daily ☐A few times a week ☐Once a week ☐Rarely or never

FAMILY HISTORY

DOES OR HAS ANYONE IN YOUR FAMILY (BLOOD RELATIVE) HAVE OR HAD ANY OF THE FOLLOWING?

YES	NO	CONDITION	WHICH RELATIVE / EXPLANATION
☐	☐	Heart disease	
☐	☐	High blood pressure	
☐	☐	Stroke	
☐	☐	Heart attack	
☐	☐	Diabetes	
☐	☐	Arthritis	
☐	☐	Thyroid disease	
☐	☐	Cancer	

COMMENTS

Please use this space for any additional comments on your health or this exam. You may use the back of this form if necessary.

SIGNATURE / ACKNOWLEDGEMENT

I certify that I have reviewed the foregoing information supplied by me ant that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for the purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

Printed name of examinee ______ Signature of examinee ______ Date ______

DO NOT WRITE IN THIS SPACE – MEDICAL CLINIC USE ONLY

Cheryl Acob, NP / Corky Hull, MD

Printed name of reviewer ______ Signature of reviewer ______ Date ______