WORKPRO
OCCUPATIONAL HEALTH

Initial and Interval History Questionnaire
(Completed at first visit and updated yearly by patient)

Date:	Visit Type:
Patient Name:	Company Name:
Patient address:	Company Address:
DOB:	Company Contact:
Patient SS#:	Company Phone #:
Phone #:	Cell Phone #:

1. Why are you seeing the clinician today? _____

2. List any illnesses or injuries you are currently being treated for such as high blood pressure, heart disease, asthma, high cholesterol, weight management, diabetes, migraines, etc.

   _____

   _____

3. List your hobbies: _____

4. If you are currently taking any prescription medicine, over-the-counter medicine, vitamins, herbs, nutritional supplements or birth control pills, please list them below:

   _____

5. List any medications that you are allergic to and your reaction, e.g. hives, rash, etc.

   _____

6. List any non-medication allergies such as foods, grass, mold, iodine, etc.

   _____

7. List any serious illness or conditions you had as a child: _____

8. When was your last tetanus booster? _____

9. Do you smoke? Yes ( ) No ( ) If yes, what do you smoke? _____

   Amount per day? _____ Number of years you have smoked? _____

10. How many alcoholic beverages do you drink per week? _____

11. For females only, date of last normal period: _____ currently pregnant? Yes ( ) No ( )

12. If you have had any surgeries, hospitalizations or have missed more than 5 days of work due to an illness or injury, please describe below. Please include month and year:

    _____

    _____

13. Have you ever received workers' compensation? Yes ( ) No ( )

If yes, for what reasons: _____

14. OCCUPATIONAL HISTORY: Please list your job titles over the past 10 years. List your current job first:

_____

Have you been exposed to any of the following while working or at home?

Chemicals ( ) Lead ( ) Gases ( ) Fumes ( ) Second hand smoke ( ) Loud Noise ( ) Asbestos ( )

Do you use any of the following protection at work or for home use?

Respirator ( ) Safety Glasses ( ) Hearing protection ( ) Steel tipped boots ( )

15. MEDICAL HISTORY: Have you had any of the following tests? If yes, for what reason?

MRI ( ) X-Ray ( ) EKG ( ) Stress Test ( ) Lung Testing ( ) Test for stomach problem ( )

Reason for test (s): _____

Are you missing any body parts? Yes ( ) No ( )
Are you (check one) right handed _____ or left handed _____

Review of Systems

Please check below any of the conditions or symptoms that you are experiencing:

Vision: ALL NEGATIVE ( ) Wear glasses/contact ( ) Tearing ( ) Blurred Vision ( )
Hearing: ALL NEGATIVE ( ) Loss of Hearing ( ) Ringing of ears ( )
Neurological: ALL NEGATIVE ( ) Headaches ( ) Dizziness ( ) Stroke ( ) Numbness or Tingling ( )
Head injury ( ) Seizures ( ) Tremors ( ) Problems sleeping ( )
Other: _____
Musculosketal: ALL NEGATIVE ( ) Fracture ( ) Back pain ( ) Shoulder Pain ( ) Knee Pain ( ) Wrist Pain ( )
Ankle pain ( ) Neck Pain ( ) Joint Pain ( ) Unsteady Walking ( )
Other: _____
Cardiovascular: ALL NEGATIVE ( ) High Blood Pressure ( ) Heart Attack ( ) Chest Pain ( ) Palpitations ( )
Other: _____
Respiratory: ALL NEGATIVE ( ) Asthma ( ) Lung Cancer ( ) Emphysema ( ) Cough ( ) Shortness of Breath ( )
Other: _____
Circulatory: ALL NEGATIVE ( ) Swelling of the Hands/Feet ( ) Blood Clots ( ) Sickle Cell Anemia ( )
Other: _____
Endocrine: ALL NEGATIVE ( ) Thyroid Problems ( ) Changes in Weight > than 10 lbs in < 1 year ( ) Diabetes ( )
Other: _____
GI: ALL NEGATIVE ( ) Stomach Ulcers ( ) Blood in Stool ( ) Gallstones ( ) Hernia ( ) Hepatitis ( )
Other: _____
Emotional: ALL NEGATIVE ( ) Anxiety Disorder ( ) Depression ( ) Mood Disorder ( ) Panic Attacks ( )
Other: _____

I certify that this information is correct to the best of my knowledge.

_____
Patient's Signature Date

Clinician's Notes: _____

Reviewed by: _____ Date: _____