

Corporate Occupational Health Solutions, LLC

Company:

Date of Service:

Patient ID:

Contact:

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Form: F-HXCOMP

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Allergies: Latex: \_\_\_ Yes \_\_\_ No
Medication Allergies: \_\_\_\_\_
Other Allergies: \_\_\_\_\_

Last Tetanus booster: \_\_\_\_\_
Current Medications: \_\_\_\_\_

Current Physician: \_\_\_\_\_

Medical Illnesses - check all that apply:

\_\_\_ High Blood Pressure \_\_\_ Heart Disease
\_\_\_ Lung Disease \_\_\_ Kidney Disease
\_\_\_ Diabetes \_\_\_ Anemia
\_\_\_ Seizures \_\_\_ Cancer
\_\_\_ Stomach or Bowel Disorders: \_\_\_\_\_
\_\_\_ Fractures & Joint Injuries: \_\_\_\_\_
\_\_\_ Other: \_\_\_\_\_
Surgeries: \_\_\_\_\_

Social History - Check all that apply :

\_\_\_ Tobacco use \_\_\_ Cigarettes: \_\_\_ packs/day \_\_\_ years
\_\_\_ Cigars: \_\_\_ per day \_\_\_ years
\_\_\_ Pipe: \_\_\_ years
\_\_\_ Chew/Snuff: \_\_\_ years
\_\_\_ Alcohol use \_\_\_ Drinks per week

Place an X in the box if you have any of the conditions below now or in the past: (Caregivers: please comment on positive responses):

Vision (Vision)

\_\_\_ 1. Do you use glasses?: Heart/Vascular
Do you have:
\_\_\_ For reading \_\_\_16. Chest pain on effort
\_\_\_ For distant vision \_\_\_17. High blood pressure
\_\_\_ Contacts \_\_\_18. Shortness of breath
\_\_\_ 2. Are you color blind? \_\_\_19. Swelling of ankles
\_\_\_20. Heart murmur
3. Do you have: Have you had:
\_\_\_ Retinal disease \_\_\_21. Heart attack
\_\_\_ Cataracts \_\_\_22. Stroke
\_\_\_ Glaucoma \_\_\_23. Rheumatic fever
\_\_\_ 4. Do you use eye medicine? \_\_\_24. Heart failure
\_\_\_ 5. Have you had eye surgery? \_\_\_25. Heart surgery
\_\_\_ 6. Have you had laser exposure?

Hearing

Do you have

- 7. Difficulty hearing
- 8. Ear disease
- 9. Ringing in the ears
- 10. Abnormal hearing test
- 11. Do you use a hearing aid?
- 12. Have you had ear surgery?
- 13. Ruptured ear drum?
- 14. Exposure to gunfire?
- 15. Wear hearing protection?

Liver or Gastrointestinal

Do you have or have you had:

- 37. Hepatitis
- 38. Cirrhosis
- 39. Jaundice
- 40. Frequent indigestion
- 41. Ulcer disease
- 42. Colitis
- 43. Other intestinal problems
- 44. Do you have a hernia?
- 45. Have you had hernia surgery?

Genitourinary:

Do you or have you had:

- 46. Kidney trouble
- 47. Bladder trouble
- 48. Kidney stones

Skin:

- 49. Do you have eczema?
- 50. Do you have psoriasis?
- 51. Any other skin conditions

Neurologic

- 52. Tremors
- 53. Dizzy spells
- 54. Convulsions
- 56. Nerve damage
- 57. Serious head injury
- 58. Brain surgery
- 59. Nervous breakdown

Are you taking medication for:

- 60. Anxiety or depression
- 61. Epilepsy
- 62. Parkinson's disease

Respiratory

Do you have:

- 26. Chronic cough
  - 27. Asthma
  - 28. Bronchitis
  - 29. Hay fever
  - 30. Emphysema
- Have you had:
- 31. Tuberculosis
  - 32. Lung cancer
  - 33. Lung surgery
  - 34. Silicosis
  - 35. Asbestos
  - 36. Black lung

Blood, Endocrine

Have you had:

- 63. Anemia
- 64. Bleeding problems
- 65. Hormone problems
- 66. Diabetes
- 67. Thyroid problem

Musculoskeletal:

Do you or have you had:

- 68. Back trouble
- 69. Disc problems/surgery
- 70. Shoulder problems/surgery
- 71. Arm problems/surgery
- 72. Wrist problems/surgery
- 73. Hand problems/surgery
- 74. Hip problems/surgery
- 75. Leg problems/surgery
- 76. Knee problems/surgery
- 77. Ankle problems/surgery
- 78. Foot problems/surgery
- 79. Broken bones
- 80. Numbness, tingling, and/or pain in hands or arms

Communicable Diseases:

Have you had:

- 81. Chicken pox
- 82. Measles
- 83. German Measles
- 84. Mumps
- 85. Hepatitis A
- 86. Hepatitis B
- 87. Hepatitis C

Please list all prior jobs:

Company Name:	Dates Employed:	Job Description:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle any of the following processes and/or jobs done in the past:

Processes:      abrasive blasting                      acid/alkali treatment  
                  degreasing                                    electroplating  
                  foundry    forging  
                  painting     welding  
                  grinding or metal machining

Industries:      flour, feed or grain                      cotton processing  
                  rubber    insulation  
                  quarry work                                    construction  
                  farming     petroleum  
                  shipyards

Circle any of the following substances to which you have had regular exposure in the workplace:

Fumes or dusts:  
                  silica                                      coal                                      asbestos                                    talc  
                  fiberglass                                    cotton dust                                sawdust  
                  other: \_\_\_\_\_

Solvents:  
                  benzene                                    carbon                                    tetrachloride                                trichloroethylene  
                  naptha                                    xylene                                    other : \_\_\_\_\_

Chemicals or gases :  
                  ammonia                                    formaldehyde                                hydrogen sulfide  
                  cyanide                                    sulfur dioxide                                chromium  
                  mercury                                    lead                                        cadmium  
                  nickel                                    other: \_\_\_\_\_

Miscellaneous:  
                  radiation                                    insecticides/herbicides  
                  cutting oils                                    motor exhaust  
                  noise

Have you ever needed medical care for exposure to any of the above?

\_\_\_ Yes      \_\_\_ No

Type of problem: Skin: \_\_\_\_\_ Lungs: \_\_\_\_\_

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

Work related injuries and illnesses:

Year: Injury and treatment:

Time off work:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes No Explain if yes

\_\_\_\_ \_  
Have you ever applied for worker's compensation or disability payments for any injury or illness which developed on the job? Explain:

\_\_\_\_\_

\_\_\_\_ \_  
Are you currently being treated by a doctor for a work related injury or illness? Explain:

\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date

f-hxcomp