MEDICAL HISTORY

Occupational Medicine, MCFARLAND CLINIC

NAME: _____ **DATE:** _____

What is your (proposed) job title/duties? _____

II. SOCIAL HISTORY:

SMOKING HISTORY
{ } Never smoked
{ } Ex-Smoker
{ } Current Smoker

IF EVER SMOKED/USED TOBACCO
{ } Cigarettes
{ } Cigar { } Pipe
{ } Snuff { } Chewing

How Many Years Smoked? _____
Average Packs/day Used? _____
If Stopped, What Year? _____

ALCOHOL USE
{ } Never/Rare (0-3 drinks/month)
{ } Occasionally (1-4 drinks/week)
{ } Frequently (5 or more drinks/week)
{ } Any alcohol use in the past 3 days?

List Hobbies/Sports_____

List Additional Jobs _____

III. FAMILY HISTORY: Have your blood relatives (mother, father, brothers or sisters) ever had any of the following:

ITEM	YES	NO	ITEM	YES	NO	ITEM	YES	NO
Stroke (before age 55)			High Cholesterol			Asthma/Emphysema		
Heart Trouble (before 55)			Seizures			Colon/Breast Cancer		
High Blood Pressure			Diabetes			Chronic Anemia		

IV. PERSONAL HISTORY: Has a doctor ever told you that you have any of the following? (Check if yes or no)

ITEM	YES	NO	ITEM	YES	NO	ITEM	YES	NO	ITEM	YES	NO
Heart Attack/Disease			Asthma			Kidney/Disease/Stones			Joint or Bone Problems		
Abnormal EKG			Asbestosis			Sleep Disorder			Back or Neck Problems		
High Blood Pressure			Emphysema			Stomach Ulcers			Pinched Nerve		
Circulation Problems			Collapsed Lung			Seizures/Epilepsy			Carpel Tunnel Syndrome		
Stroke/Paralysis			Tuberculosis			Concussion			Blindness or Color Blind		
Severe Anemia			Lung Problems			Hemia/Rupture			Acne, Eczema or Psoriasis		
Cancer/Leukemia			Thyroid Disease			Migraines			Severe Allergy		
Hepatitis/Cirrhosis			Heat Stroke			Drug/Alcohol Abuse			Depression/Anxiety		

V. MEDICATIONS: List any prescription or over-the-counter medications that you use:

_____

VI. SURGICAL HISTORY: List any surgeries that you have had or which you have been advised to have:

_____

VII. REVIEW OF SYSTEMS: During the past 12 months, have you had…….(check yes or no)

ITEM	YES	NO	ITEM	YES	NO	ITEM	YES	NO
Weight Loss/Gain (10+pounds) Without dieting or reason			Tingling, Burning, or Numbness in Hands or Feet			Rash or Skin problem		
						Neck/Back Pain lasting longer than 1 week		
Unusual Tiredness			Troublesome Shortness of Breath			Joint Problems/Pain Which joints:		
Unexplained Bruising			Pain or Pressure in Chest					
Frequent/daily Fevers			Abnormal Heart Beat			Weakness of Arms or Legs		
Persistent Cough			Swollen Feet/Ankles			Depression/Anxiety		
Wheezing			Poor Circulation			Trouble w/Memory/Concentration that interferes with work		
Frequent Chest Colds			Fainting/Blackouts			Balance Difficulty		
Chronic Head Congestion			Chronic Diarrhea or Constipation			Problems w/Reproductive Organs Enlarged Lymph Nodes		
Coughed Vomited Blood			Frequent Nausea/Vomiting					
Frequent Bleeding Nose/Gums			Abdominal Pain/Ulcers			Significant Heat/Cold Intolerance		
Loss of Taste/Smell Sense			Black or Bloody Stools			Significant Claustrophobia		
Severe Headaches lasting longer than a week			Bloody/Dark Brown Urine			**For Women:**		
			Difficulty with Urination			Are you pregnant?		
			Bulge or Hernia in Groin			Date of last menstrual period (m/d)		

VIII. EXPLANATION/COMMENTS: (Use back of this page if necessary)

IX. EMPLOYEE CERTIFICATION: I have answered the above completely and accurately to the best of my knowledge.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

X. MEDICAL SIGNATURE: _____ **DATE:** _____

(Place patient label on the back of this form)