MMC HealthWorks
Your Health Management Partner

MMC HealthWorks General Health and Occupational History

Name: Last, First, MI	Company	Today's Date
Address	Job Title or Function	Age to Nearest Year
City, State, ZIP	SSAN or Employee Number	Personal Physician

Recent Health History: (use reverse if more space needed)

Yes	No		Comments
		Are you currently under the care of a physician for any chronic conditions? If yes please list.	
		Do you take any medications on a regular basis? If yes, please list.	Medication: Dose:
		Have you missed any work during the past year due to an injury or other health condition? If yes, please list condition, approx. date, and time missed	

Life Style Factors:

Yes	No	Factor	Comments
		Do you currently (or within the past year) use any form of tobacco? Circle all that apply. • Cigarettes • Cigars • Pipe • Chew • Snuff	If used, how much? Per day? Per Week? No. of years?
		Do you exercise regularly? If so, • What type? • How often? • Minutes per session?	
		Have you ever suspected or been told by anyone that you may have a problem with drugs or alcohol?	
		During the past three years, have you received therapy or treatment for substance abuse or misuse (alcohol, legal or illegal drugs, other substances)? If so, give dates, facility where treated, and physician's name.	

Name:_____ **MMC HealthWorks General Health and Occupational History**

Life Style Factors:			
Yes	**No**	**Factor**	**Comments**
		Have you ever attended alcoholics anonymous or a similar program?	
		Do you consider yourself to be overweight or have you been advised by a healthcare provider to lose weight?	Please describe any medically supervised treatment:

Immunization History:			
		Other than localized swelling / pain, have you ever had a significant reaction to an immunization? If so, what vaccine was involved? Please describe reaction.	
		Please indicate if you have received any of the following vaccines / immunizations and the most recent (approximate) date:	
Yes	**No**	**Immunization**	**Date**
		Tetanus (Td or DPT)	
		MMR	
		HiB	
		VZV (varicella)	
		Influenza	
		Hepatitis A	
		Hepatitis B	
		Polio	
		Rabies	
		Anthrax	
		Yellow fever	

Yes	**No**	**Immunization**	**Date**
		Cholera	
		Plague	
		BCG	
		Smallpox	

Review of Systems:
Do you currently have, or have you experienced any of the following in the past?

Now	Past		Now	Past	
		Cardiovascular			
		Angina			Heart attack
		Heart murmur			Abnormal valve
		Irregular heart beat			Heart failure
		Cardiac cath			Artery stent
		Abnormal ECG			Abnormal stress test
		High blood pressure			Stroke / TIA
		Varicose veins			Leg cramps-walking
		Aortic aneurysm			Other
		Pulmonary			
		Chronic cough			Asthma
		Emphysema			Chronic bronchitis
		Pneumonia			Pulmonary embolus
		Tuberculosis			Positive TB test
		Lung cancer			Sarcoidosis
		Collapsed lung			Other
		EENT			
		Wear glasses			Wear contacts
		Color blindness			Eye injury
		Cataract			Glaucoma
		Hearing loss			Ringing in ears
		Vertigo/dizziness			Ear injury
		Nasal allergies			Nasal polyps

Name:_____ **MMC HealthWorks General Health and Occupational History**

Now	Past		Now	Past	
		Nosebleeds			Swallowing problem
		Other			
		Neuro-psych			
		Depression			Anxiety
		PTSD			Bipolar disorder
		Claustrophobia			Migraines
		Seizures			Other
		Gastrointestinal			
		Heartburn/reflux			Esophageal spasm
		Vomit blood			Ulcer
		Pancreas problem			Gall bladder disease
		Hepatitis			Cirrhosis
		Spastic colon			Crohn's disease
		Inflammatory bowel			Diverticulosis
		Colon polyps			Rectal bleeding
		Other			
		Kidney/renal			
		Blood in urine			Kidney failure
		Kidney stones			Kidney infections
		Bladder infections			Bladder cancer
		Other			
		Bone and joint			
		Broken bones			Arthritis
		Knee problem			Ankle/foot problem
		Hip problem			Back problem
		Shoulder problem			Elbow problem
		Hand/wrist problem			Night leg cramps
		Other			
		Endocrine			
		Diabetes			Thyroid disease
		Overweight/obesity			Gout

Now	Past		Now	Past	
		Other			
		Blood			
		Anemia			Bleeding disorder
		Leukemia			Lymphoma
		Enlarged spleen			Absent spleen
		Sickle trait/disease			Thallasemia
		Hemochromatosis			G6PD deficiency
		Other			
		Connective tissue			
		Systemic lupus			Scleroderma
		Rheumatoid arthritis			
		Other			

Any other significant conditions?

Surgical History

Have you had any of the following surgical procedures? If so, please check and give approximate date.

√	Surgical procedure	Date
	Vision correction	
	Heart	
	Peripheral vascular	
	Back	
	Major joint (shoulder, knee, hip) repair or replacement	
	Obesity (bariatric)	
	Other:	

Cancer Treatment

	Have you ever received radiation or chemotherapy?	Date: Diagnosis:

Occupational history, current job:
How long have you worked in your current job?
What are your major functions and / or responsibilities in your current job?
Do you have exposure to radiation or any known or suspected substances associated with health risks? If so please list.* (*Do not violate classification or security requirements)
Do you use or wear protective garments or equipment in the normal performance of your present job? If yes, please list:

Occupational history, previous jobs:		
starting with your immediate prior job and going back, please list previous jobs for the past 15 years:		
Job title	Major requirements / functions	Years
Have you ever experienced a work related illness or injury? If yes, please describe and give date(s):		

Occupational history, previous exposures:
Have you ever had a job in which you were exposed to any of the following? Please give approximate number of years exposure in the column next to substance or environment.

Acrylonitrile		Isocyanates	
Arsenic		Lasers	
Antimony		Lead	
Arm/hand vibration		Man made mineral fibers	
Asbestos		Mercury	
Benzene		Methanol	
Beryllium		Methylene chloride	
Blood borne pathogens		Nickel	
Cadmium		Nitrogen oxide	
Carbon disulfide		Noise	
Carbon tetrachloride		Paints, thinners	
Chlordane		Pesticides/organophosphates	
Chloroform		Petroleum products, fuels	
Chlorine		Phenols	
Chromium/chrome processes		Phosgene	
Coal/coal dust		Polychlorinated biphenyls (PCBs)	
Coke oven fumes		Radiation (alpha, beta, gamma)	
Cutting oils, coolants		Radioactive materials	
Cyanide		Silica, silica dust	
Degreasing solvents		Sulfur dioxide	
Dioxin		Toluene	
Dust/nuisance dust		Toxic waste	
Epoxy resins, adhesives		Trichloroethylene	
Ethanol		Uranium, transuramics	
Fluorides		Vinyl chloride	
Formaldehyde		Welding/soldering fumes	
Galvanizing processes		Wood/saw dust	
Glycols		Zinc	
Grain dust		Others:	
Hydrofluoric acid			
Hydrogen sulfide			

Others: Have you had any other significant past occupational exposures that we have not asked about? Please list:

Additional space if needed:

I certify that the information I have provided is accurate and complete to the best of my knowledge.

Signature:_____

Date: ____/____/_____

(02.07.2006)