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Periodic Medical Questionnaire

Try to answer all questions as correctly as possible, even if they do not seem to be important to you.

Name:
Date:
Address:
City:
State:
Zip:
Personal Physician:
Name of Employer:
Employer Address:
Job Title:
Social Security #:
Date of Birth:
Home Phone:
Business Phone:

Type of Exam:

☐ Annual/Periodic
☐ Exit

MEDICAL HISTORY AND PHYSICAL EXAM page 1

PERSONAL HISTORY

Do you smoke? ☐ Yes ☐ No	#Packs smoked/day	Have you smoked in the past?	#Yrs. Smoked	When did you Quit? Date:

Do you ever drink alcoholic beverages? ☐ Yes ☐ No	If yes, how many servings do you have in a week?	When was your last drink?

Have you ever had a drug or alcohol problem?	If yes, explain:

OCCUPATIONAL HISTORY

Usual Occupation	Present Job	Number of years at present occupation:
Have you been injured at work in the past year? ☐ Yes ☐ No	If yes, give date and describe:	Did you receive Workers' Comp? ☐ Yes ☐ No

PRESENT MEDICATIONS

Drug	Dose/Time	Drug	Dose/Time	ALLERGIES (Medication & Environmental)
1 .		7.		
2.		8.		
3.		9.		
4.		10.		
5.		11.		
6.		12.		

HOSPITALIZATIONS/OPERATIONS	Have you been hospitalized or have you had an operation or injury since your last examination? If not, please check and proceed. ☐ No change since last exam
1.	
2.	
3.	

ACCIDENTS/INJURIES ☐ No change since last exam (i.e., broken bones/fractures, sprains, including cartilage and ligament injuries)

Describe	Date

IMMUNIZATIONS If there are any changes since last year, please note. If not, please check and proceed.
☐ No change since last exam.

Immunization	Date	Immunization	Date	
Diphtheria Tetanus		Hepatitis B Vaccine		Other:
		Injection 1:		TB Test Results (most recent) Date: Results:
		Injection 2:		Last Chest X-ray: Date: Location:
		Injection 3:		

Comments and/or Explanations

MEDICAL HISTORY AND PHYSICAL EXAM page 2

Review of Systems – Do you have any new or persistent symptoms or medical problems since last exam?
☐ Yes ☐ No If yes, completes the following and elaborate. If no, proceed to following page.

			Yes	No
General	Hepatitis	1		
	Cancer	2		
	Liver Disease	3		
	Anemia	4		
	Fevers	5		
	Recent weight loss in past 6 months	6		
	Chills or fever	7		
	Night Sweats	8		
	Swollen glands	9		
	Swelling in your groin or armpit	10		
	Fatigue	11		
	Allergies	12		
Skin	Rashes	13		
	Poor healing	14		
	Easy bruising	15		
	Change in lumps/moles	16		
Eyes	Blurring	17		
	Double vision	18		
	Cataracts	19		
	Glaucoma	20		
Ears	Wear hearing aid	21		
	Ringing	22		
	Deafness/trouble hearing	23		
	Infections	24		
Nose, Sinus	Infections	25		
	Bleeding	26		
	Nasal congestion without a cold	27		
Throat	Infections/Strep	28		
	Hoarseness	29		
	Trouble swallowing	30		
Endocrine	Thyroid Disease	31		
	Diabetes	32		
	Excessive Thirst	33		
	Excessive hunger	34		
	X-ray treatment to head, neck	35		
Bones/ Joints	Back/spine Injury	36		
	Back Surgery	37		
	Pain	38		
	Stiffness	39		
	Swelling	40		
	Arthritis	41		
	Pain on motion	42		
	Limited motion	43		
Nerves	Seizures	44		
	Tremors	45		
	Fainting	46		
	Numbness	47		

			Yes	No
Nerves (cont'd)	Weakness	48		
	Dizziness	49		
	Trouble Walking	50		
	Anxiety	51		
	Depression	52		
	Headaches	53		
Lungs	Cough	54		
	Sputum	55		
	Cough up blood	56		
	Shortness of breath	57		
	Wheezing	58		
	Pneumonia	59		
	Asthma	60		
	Tb	61		
	Bronchitis	62		
	Emphysema	63		
Heart	Chest Pain	64		
	Heart Attack	65		
	High blood pressure	66		
	Shortness of breath	67		
	on exertion	A		
	at rest	B		
	Palpitations	68		
	Ankle swelling	69		
	Rheumatic fever	70		
	Heart murmur	71		
	Irregular heartbeat	72		
Abdomen	Nausea/vomiting	73		
	Change in bowel habits	74		
	Bloody stools/Black tarry stools	75		
	Heartburn	76		
	Ulcer disease	77		
	History of jaundice	78		
	Abdominal pain	79		
	Hernia	80		
Genito-Urinary	Urgency or increased frequency	81		
	Burning	82		
	Bleeding	83		
	Kidney Stones	84		
	Infections	85		
Vascular	Circulation problems	86		
	Stroke	87		
	Phlebitis	88		

Comments and/or explanation of positive or abnormal responses:

Employee Signature:_____________________________________Date:_______________________________________

Medical Reviewer Signature:______________________________Date:____

Occupational and Environmental Exposures page 3

Below is a list of agents or exposures you might have encountered in your work or outside work. The columns differentiate where you might have encountered exposures. Under these categories there are boxes marked “yes”, “low”, “med”, “high”. If exposed, check yes, then note the degree of exposure.

	A. Current Job				B. Outside Work			
Solvents	**Yes**	**Low**	**Med**	**High**	**Yes**	**Low**	**Med**	**High**
Alcohols (e.g., methyl, wood)	☐	☐	☐	☐	☐	☐	☐	☐
Paints, varnish, degreasers	☐	☐	☐	☐	☐	☐	☐	☐
Carbon tetrachloride	☐	☐	☐	☐	☐	☐	☐	☐
Benzene, Toluene, Xylene	☐	☐	☐	☐	☐	☐	☐	☐
Tri-, Tetrachlorethylene	☐	☐	☐	☐	☐	☐	☐	☐
Benzene (gas) Petroleum Ether	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐
Elements and Metals								
Aluminum	☐	☐	☐	☐	☐	☐	☐	☐
Arsenic	☐	☐	☐	☐	☐	☐	☐	☐
Cadmium	☐	☐	☐	☐	☐	☐	☐	☐
Chromium	☐	☐	☐	☐	☐	☐	☐	☐
Copper	☐	☐	☐	☐	☐	☐	☐	☐
Lead	☐	☐	☐	☐	☐	☐	☐	☐
Mercury	☐	☐	☐	☐	☐	☐	☐	☐
Nickel	☐	☐	☐	☐	☐	☐	☐	☐
Zinc	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐
I. Fumes and Dust								
Asbestos	☐	☐	☐	☐	☐	☐	☐	☐
Plastic fumes	☐	☐	☐	☐	☐	☐	☐	☐
Welding fumes	☐	☐	☐	☐	☐	☐	☐	☐
Other fumes:	☐	☐	☐	☐	☐	☐	☐	☐
Glass (e.g. fiberglass)	☐	☐	☐	☐	☐	☐	☐	☐
Slicia (e.g. sand)	☐	☐	☐	☐	☐	☐	☐	☐
Plaster	☐	☐	☐	☐	☐	☐	☐	☐
Wood	☐	☐	☐	☐	☐	☐	☐	☐
Isocyanates	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐
V. Other Chemicals	☐	☐	☐	☐	☐	☐	☐	☐
Acids	☐	☐	☐	☐	☐	☐	☐	☐
Alkali	☐	☐	☐	☐	☐	☐	☐	☐
Ammonia	☐	☐	☐	☐	☐	☐	☐	☐
Detergent and Soaps	☐	☐	☐	☐	☐	☐	☐	☐
Dyes	☐	☐	☐	☐	☐	☐	☐	☐
Formaldehyde	☐	☐	☐	☐	☐	☐	☐	☐
Pesticides	☐	☐	☐	☐	☐	☐	☐	☐
Plastic resins	☐	☐	☐	☐	☐	☐	☐	☐
PCB	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐
V. Miscellaneous								
Heavy lifting	☐	☐	☐	☐	☐	☐	☐	☐
Improper lighting	☐	☐	☐	☐	☐	☐	☐	☐
Excess heat or cold	☐	☐	☐	☐	☐	☐	☐	☐
Emotional stress	☐	☐	☐	☐	☐	☐	☐	☐
Ionizing radiation (e.g., x-ray, radioisotopes)	☐	☐	☐	☐	☐	☐	☐	☐
Nonionizing radiation (e.g. microwave, UV)	☐	☐	☐	☐	☐	☐	☐	☐
Noise	☐	☐	☐	☐	☐	☐	☐	☐
Vibration	☐	☐	☐	☐	☐	☐	☐	☐
Prolonged sitting or standing	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐

PERIODIC PULMONARY QUESTIONNAIRE
29CFR 1910.1001 Required for Asbestos Examinations

1.	Name				
2.	Social Security #		3.	Clock Number:	
4.	Present Occupation:				
5.	Plant:				
6.	Address:				
7.	City:	State:		Zip Code:	
8.	Telephone No.:	9.	Interviewer:	10.	Date:
11.	What is your marital status? ☐ Single ☐ Married ☐ Widowed ☐ Separated/Divorced				

OCCUPATIONAL HISTORY

12a.	In the past year, did you work full time (30 hours per week or more) for 6 months or more? ☐ Yes ☐ No	
If yes to 12a:		
12b.	In the past year, did you work in a dusty job? ☐ Yes ☐ No ☐ Does not Apply	
12c.	Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe	
12d.	In the past year, were you exposed to gas or chemical fumes in your work? ☐ Yes ☐ No	
12e.	Was exposure: ☐ Mild ☐ Moderate ☐ Severe	
12f.	In the past year, what was your:	
	Job occupation?	Position/job title?

RECENT MEDICAL HISTORY

13a.	Do you consider yourself to be in good health? ☐ Yes ☐ No If no, state reason					
13b.	In the past year, have you developed:					
	Epilepsy	☐ Yes	☐ No	Bladder Disease	☐ Yes	☐ No
	Rheumatic Fever	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
	Kidney Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
	Jaundice	☐ Yes	☐ No			

CHEST COLDS AND CHEST ILLNESS

14.	If you get a cold, does it usually go to your chest? (Usually means more than ½ the time)
	☐ Yes ☐ No ☐ Don't get colds
15a.	During the past year have you had any chest illnesses that have kept you off work, indoors at home, or in bed? ☐ Yes ☐ No ☐ Does not Apply
If yes to 15a:	
15b.	Did you produce phlegm with any of these chest illnesses? ☐ Yes ☐ No ☐ Does not Apply
15c.	In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more? ☐ Number of Illnesses ☐ No such Illnesses

RESPIRATORY SYSTEM

16.	In the past year have you had:					
	Asthma	☐ **Yes** ☐ **No**		**Hay Fever**	☐ **Yes** ☐ **No**	
	Bronchitis	☐ **Yes** ☐ **No**		**Other Allergies**	☐ **Yes** ☐ **No**	
	If yes, please explain:					