Reading Hospital Occupational Health Services
MEDICAL HISTORY QUESTIONNAIRE

Today's Date	Name (print)
Date of Birth	Job related to today's appointment

Have you ever had a work-related injury that caused you to be out of work or been unable to hold a job or refuse employment because of a medical condition? ❑ Yes ❑ No If yes, please explain: _____

Please ✔ in Yes or No column, and describe.

Do you:	Y	N	If yes, how much?
use tobacco?			
drink alcohol?			

Do you have any allergies, including foods, medicines or latex? ❑ Yes ❑ No If yes, please list: _____

_____

Are you taking any medications? ❑ Yes ❑ No If yes, please list prescriptions and non-prescription medications, vitamins, inhalers, herbals, and alternative remedies: _____

_____

Have you fallen or lost your balance without reason or developed a fear of falling within the last month? ❑ Yes ❑ No

Have you had any surgery? ❑ Yes ❑ No If yes, please list and give dates: _____

_____

Violence and abuse are increasing problems in our society. Do you feel safe at home? ❑ Yes ❑ No

Please check ✔ YES or NO to EACH and EVERY question. Have you ever have any of the following conditions?

	Y	N		Y	N		Y	N
Seasonal Allergies, hayfever			Liver Disease			Changes in Weight		
Eye Injuries/Disorders			Gall Bladder Disease			Vision Changes		
Glaucoma or Cataracts			Ulcers			Difficulty Hearing/Ear pain		
Goiter or Thyroid Problems			Diabetes			Palpitations/Pounding Heart		
Anemia or blood disorders			Hernia			Chest Pain or Pressure, Angina		
Heart attack/heart surgery or stent			Kidney Disease			Shortness of Breath		
Heart Murmur/Heart Failure			Back or Neck Injury			Dizziness or Fainting Spells		
Blood Clots			Foot Problems			Cough or phlegm		
High Blood Pressure			Arthritis,			Abdominal Pain		
Stroke			Carpal Tunnel Syndrome			Joint pain		
COPD, Emphysema			Tendonitis			Skin Rash		
Pneumonia			Gout			Numbness/Tingling		
Tuberculosis or positive TB test			Fractures			Frequent Headaches		
Asthma			Head Injury			Anxiety or Depressed Mood		
Obstructive Sleep Apnea			Epilepsy/Seizures			Hives		
Bowel or Rectal Disease			Cancer			Seasonal Allergy Symptoms		

Please list OTHERS and explain any YES answers: _____

_____

The preceding statements are true to the best of my knowledge and I understand this will become part of my medical record.

_____ / am/pm

Employee Signature — Date/Time

_____ / am/pm

Signature of Reviewing Healthcare Provider — Date/Time