**MD MEDICAL CLINICS** Occupational Services
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## HEALTH QUESTIONNAIRE

| NAME (First, Last) | DATE OF BIRTH | AGE | SEX M F | MARITIAL STATUS: S M W D |
|---|---|---|---|---|
| ADDRESS (Number, Street) | SOCIAL SECURITY NO. | | HOME PHONE NO. | |
| CITY, STATE, ZIP | COMPANY | | | |

**PLEASE ANSWER ALL QUESTIONS, IF ANY ANSWER IS YES, PLEASE DESCRIBE ON LINES BELOW**

| CHECK EACH ITEM | YES | NO |
|---|---|---|
| 1. Are you allergic to any foods or medication? If so, describe below. | | |
| 2. Are you taking prescription medication? If so, list below (dose and frequency) | | |
| 3. As part of your work, have you been exposed to any toxic substances? | | |
| 4. Have a prior history of dermatitis (skin problems) or chemical skin sensitization? | | |
| 5. Smoke Cigarettes? How much? _____ Drink Alcohol? How much? _____ | | |

| CHECK EACH ITEM | YES | NO |
|---|---|---|
| 6. Have you had any major illness or injury? If so, describe below. | | |
| 7. Have you been hospitalized or had any operations? If so, describe below. | | |
| 8. Have you ever been advised to have an operation? If so, describe below. | | |
| 9. Has any blood relative had: (If Yes, Circle each one) Cancer Diabetes Heart Disea Arthritis Mental Illness Tuberculosi High Blood Pressure Allergies or Asthma | | |

**Describe any *Yes* answers given above:**

**PRIOR TO YOUR INJURY, HAVE YOU EVER HAD:**

| CHECK EACH ITEM | Yes | No |
|---|---|---|
| 1. Wear glasses or reading glasses. | | |
| 2. Eye Injury, Infection, Pain | | |
| 3. Decreased Vision or Blindness/Double Vision | | |
| 4. Ringing in Ears/Loss of Hearing/Ruptured Eardrums | | |
| 5. Ear Pain, Infection, Discharge | | |
| 6. Recent Gain or Loss of Weight | | |
| 7. Weakness, Fatigue, Loss of Appetite | | |
| 8. Nervous Condition, Depression | | |
| 9. Cancer, Tumor, Growth, Cyst | | |
| 10. Rashes, Allergies, Hives | | |
| 11. Frequent or Severe Headaches | | |
| 12. Head Injuries | | |
| 13. Epilepsy, Fits, Convulsions | | |
| 14. Problems Sleeping/Staying Asleep/Sleep Disorders | | |
| 15. Psychiatric Disorders | | |
| 16. Broken Bones/Joint Dislocation | | |
| 17. Arthritis/Rheumatism/Bursitis | | |
| 18. Voice Changes/Hoarseness | | |
| 19. Dental/Gum Disease | | |
| 20. Recurrent Sore Throat | | |
| 21. Chronic/Recurrent Cough/Cold | | |
| 22. Asthma or Wheezing | | |
| 23. Shortness of Breath | | |
| 24. Tuberculosis/Lived with someone who did | | |

| CHECK EACH ITEM | Yes | No |
|---|---|---|
| 25. Heart Trouble | | |
| 26. High Blood Pressure | | |
| 27. Palpitation/Pounding Heart | | |
| 28. Swelling Feet/Ankles | | |
| 29. Pain/Stiffness of Neck/Back | | |
| 30. Pain in Shoulders/Arms/Hands | | |
| 31. Varicose Veins | | |
| 32. Numbness Any Part of Your Body/Frequent Leg Cramps | | |
| 33. Coughing or Vomiting of Blood | | |
| 34. Frequent Indigestion/Frequent Use of Antacids | | |
| 35. Ulcers | | |
| 36. Frequent Constipation/Diarrhea or Bowel Changes | | |
| 37. Bleeding from Bowels/Black Stools/Hemorrhoids | | |
| 38. Rupture or Hernia | | |
| 39. Jaundice/Yellow Skin or Eyes | | |
| 40. Diabetes/High Blood Sugar | | |
| 41. Kidney/Bladder Infection/Stone | | |
| 42. Pain or Burning While Urinating/Frequent Urination | | |
| 43. Treated for Anemia | | |
| 44. Venereal or Any Other Sexually Transmitted Disease | | |
| 45. Blood/Sugar/Protein in Urine | | |
| 46. Pain in Hips/Knees/Ankles | | |
| 47. Wounds take a long time to heal | | |
| 48. Become exhausted after minimal activity | | |

**Briely describe any *Yes* answers given above:**

**I declare under penalty of perjury under the laws of the State of California, that the above is true and correct to the best of my knowledge.** **Reviewe**

PATIENT'S SIGNATURE

DATE