UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER

OCCUPATIONAL HEALTH HISTORY FORM

Name: ____ University ID #: __________________________ Date: ___________

Drug allergies (list name and reaction): ____

Medications (prescription, over-the-counter): ____

Gender assigned at birth: □ Male □ Female □ Decline to answer, please explain: ___________________________________

Current gender identity: □ Male □ Female □ FTM/Transman □ MTF/Transwoman □ Gender queer
□ Something else □ Decline to answer, please explain: ___________________________________

Do you think of yourself as: □ Straight or heterosexual □ Gay/lesbian or homosexual
□ Bisexual □ Something else □ Don't know

PERSONAL HISTORY

Problem	Yes	No	Unsure	Please explain if you answered "yes"
Headaches/Migraines/Epilepsy/Seizures	□	□	□	
Lung Disease (Asthma, Tuberculosis, etc.)	□	□	□	
Heart Disease (High Blood Pressure, Murmurs, etc.)	□	□	□	
High Cholesterol	□	□	□	
Stroke/Blood Clots	□	□	□	
Stomach or Intestinal Problems (Reflux, Crohn's disease, Gluten/Lactose intolerance, Irritable bowel, etc.)	□	□	□	
Liver Disease (Mononucleosis, Hepatitis, Jaundice, etc.)	□	□	□	
Gallbladder Disease	□	□	□	
Urinary Problems (Infections, Kidney Stones, etc.)	□	□	□	
Joint, Muscle or Bone (Scoliosis, Fractures, etc.)	□	□	□	
Blood Problems (Anemia, Clotting, Sickle Cell, etc.)	□	□	□	
Endocrine Problems (Diabetes, Thyroid, PCOS, etc.)	□	□	□	
Skin/Hair Problems (Acne, Rashes, etc.)	□	□	□	
Cancer (specify type)	□	□	□	
Birth Defects/Disabilities	□	□	□	
Mental/Behavioral (Depression, Anxiety, ADHD, etc.)	□	□	□	
Other illnesses/injuries	□	□	□	
Surgery (Tonsils, Wisdom Teeth, Appendix, Hernia, etc.)	□	□	□	
Hospitalization (admitted overnight)	□	□	□	

FAMILY HISTORY □ Adopted

Problem	Yes	No	Unsure	Please list which family members (father, mother, siblings, grandparents, etc.)
Lung Disease (Asthma, Tuberculosis, etc.)	□	□	□	
Heart Disease (High Blood Pressure, Murmurs, etc.)	□	□	□	
Heart Attack BEFORE age 50	□	□	□	
High Cholesterol	□	□	□	
Stroke/Blood Clots	□	□	□	
Diabetes	□	□	□	
Thyroid Disease	□	□	□	
Breast Cancer	□	□	□	
Other Cancer(s) (specify type)	□	□	□	
Mental/Behavioral (Depression, Anxiety, ADHD, etc.)	□	□	□	
Other illnesses	□	□	□	

PLEASE COMPLETE THE REVERSE SIDE

SOCIAL HISTORY

	Yes	No	What type?	How often?
Do you use tobacco?	☐	☐		
Do you drink alcohol?	☐	☐		
Do you regularly use any recreational drugs (Marijuana, Cocaine, Heroin, LSD, Shrooms, Ecstasy, etc.)?	☐	☐		
Do you regularly use any prescription drugs that is not prescribed to you (Adderall, Ritalin, opiates, benzos, etc.)?	☐	☐		

OCCUPATIONAL HEALTH HISTORY

Do you know or have you ever worked with any of the following agents/hazards?	Yes	No	Please explain if you answered "yes". State when you last worked with the agent and how long.
Asbestos	☐	☐	
Biological agents/hazards (Type________________)	☐	☐	
Excessive heat	☐	☐	
Excessive noise	☐	☐	
Exhaust	☐	☐	
Formaldehyde	☐	☐	
Pesticides	☐	☐	
Radioactive material solvents (Type ____________)	☐	☐	

PHYSICAL LIMITATIONS

Do you have a physical condition that would impair your ability to do any of the following?	Yes	No	Please explain if you answered "yes" and describe any accommodations that you require.
Stand continuously for three (3) hours?	☐	☐	
Refrain from eat or drink for three (3) consecutive hours or more?	☐	☐	
Are you or your partner currently pregnant or planning to become pregnant?	☐	☐	

IMMUNIZATIONS

Please check the boxes to indicate if you have received any of these immunizations in the past.	Yes	No	Please write the date(s) that you have received the immunization.
Tetanus (Td) or Tdap	☐	☐	
Hepatitis B	☐	☐	
Influenza (seasonal)	☐	☐	
Other related immunization(s)	☐	☐	List name(s) and date(s):