

UNIVERSITY OF MARYLAND  
UNIVERSITY HEALTH CENTER

Occupational Health  
Health History Form

Name: \_\_\_\_\_ University ID Number: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Dept: \_\_\_\_\_  
Position: \_\_\_\_\_ Supervisor: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Work E-mail Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Patient Information:**

- A) Sex: Male  Female  Transgendered  Other  \_\_\_\_\_  
B) Are you currently being treated by a doctor for any illness, injury, or other condition? Yes  No   
C) Are you currently taking any prescription, non-prescription or herbal medications? Yes  No   
If yes, list medicines: \_\_\_\_\_  
D) Are you currently under the care of a physician? Yes  No   
If yes, state why: \_\_\_\_\_  
E) List any food, drug, or chemical allergies you have: \_\_\_\_\_  
Hazardous agents or health risks in the work place: \_\_\_\_\_  
\_\_\_\_\_  
List personal protective equipment worn: \_\_\_\_\_

**Social History:**

- A) Do you have any hobbies or "side jobs" that require you to use chemicals, such as furniture stripping, sand blasting, insulation, lead, asbestos. or other hazardous material(s)? Yes  No   
If so, please describe type of business or hobby, chemicals used, and length of exposure(s): \_\_\_\_\_

- B) Habits: Do you:  
-exercise regularly? Yes  No  How many times per week? \_\_\_\_\_  
-use alcohol? Yes  No  How many times per week? \_\_\_\_\_  
-smoke cigarettes? Yes  No  \_\_\_\_\_ packs/day for \_\_\_\_\_ years  
-use illegal drugs? Yes  No  Explain: \_\_\_\_\_

**Family History:** Has anyone in your family ever had any of the following? (Include your parents, brothers and sisters, and children, if any.)

- |                   |                              |                             | Relationship |            |                              |                             | Relationship |
|-------------------|------------------------------|-----------------------------|--------------|------------|------------------------------|-----------------------------|--------------|
| A) Heart disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____        | D) Cancer? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____        |
| B) Diabetes?      | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____        | E) Stroke? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____        |
| C) High BP?       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____        |            |                              |                             |              |

**Medical History:** Do you have any history of:

- |                       |                              |                             |                        |                              |                             |
|-----------------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| A) Anemia             | Yes <input type="checkbox"/> | No <input type="checkbox"/> | J) Hernia              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| B) Asthma             | Yes <input type="checkbox"/> | No <input type="checkbox"/> | K) High Blood Pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| C) Bleeding Problem   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | L) Kidney Disease      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| D) Cancer             | Yes <input type="checkbox"/> | No <input type="checkbox"/> | M) Liver Disease       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| E) Chronic Bronchitis | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N) Pneumonia           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| F) Diabetes           | Yes <input type="checkbox"/> | No <input type="checkbox"/> | O) Seizures            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| G) Emphysema          | Yes <input type="checkbox"/> | No <input type="checkbox"/> | P) Stroke              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| H) Heart Attack       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Q) Tuberculosis        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| I) Hepatitis          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                        |                              |                             |

Have you had any history of:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments
1) Visual or hearing difficulty	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
2) Shortness of breath or chronic cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
3) Chest pain or fainting spells	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
4) Irregular heart beat or murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
5) Vomiting blood, dark stools, or heartburn	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
6) Urinary discomfort, bleeding, or frequency	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
7) Back, neck, or joint pains	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
8) Fractured bones or joint dislocation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
9) Unusual skin growths or rashes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
10) Headaches or dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
11) Experience numbness or muscle weakness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
12) Gynecological problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
13) Emotional problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
14) List any other conditions not listed above:			_____

Please list any surgeries you've had: \_\_\_\_\_

**Tests and Immunizations:** Please check box of those you have had and enter year

- |  |   |
|--|---|
| <input type="checkbox"/> Tetanus shot: _____ | <input type="checkbox"/> Rabies vaccination series: _____ |
| <input type="checkbox"/> TB test: _____      | <input type="checkbox"/> Hepatitis B: _____               |
| <input type="checkbox"/> Chest x-ray: _____  | <input type="checkbox"/> Influenza vaccine: _____         |

**Occupational History:** Do you know or have you ever worked with any of the following agents/hazards? If so, please check box and state when you last worked with the agent and how long.

- |   |   |
|---|---|
| <input type="checkbox"/> Arsenic _____      | <input type="checkbox"/> Excessive heat _____             |
| <input type="checkbox"/> Asbestos _____     | <input type="checkbox"/> Pesticides _____                 |
| <input type="checkbox"/> Benzene _____      | <input type="checkbox"/> Radioactive material _____       |
| <input type="checkbox"/> Beryllium _____    | solvents  |
| <input type="checkbox"/> Cadmium _____      | (Type _____ )   |
| <input type="checkbox"/> Epoxy resin _____  | <input type="checkbox"/> Vinyl chloride _____             |
| <input type="checkbox"/> Fiberglass _____   | <input type="checkbox"/> Biological agents/hazards _____  |
| <input type="checkbox"/> Formaldehyde _____ | (Type _____ )   |
| <input type="checkbox"/> Lead _____         | <input type="checkbox"/> Welding or soldering fumes _____ |
| <input type="checkbox"/> Mercury _____      | <input type="checkbox"/> Exhaust _____                    |
| <input type="checkbox"/> PCB's _____        | <input type="checkbox"/> Excessive noise _____            |

I understand that this physical examination is not designed, nor intended, to replace a regular physical examination, or routine medical care, by my private physician. I understand that this examination and all subsequent examinations are highly specific to evaluate my ability to perform certain tasks noted in my job description. This examination will not cover all aspects of a full physical examination.

Signature \_\_\_\_\_ Date \_\_\_\_\_