MEDCARE OCCUPATIONAL HEALTH

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PATIENT ID / RECORD # _____

Medical History Questionnaire

FORM MC-102

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

PRESENT OCCUPATION | COMPANY

MEDICAL HISTORY

Mark every line. If you answer YES to any item, explain it in the space below.

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Asthma / wheezing	☐	☐	Heart trouble	☐	☐	Neck pain	☐	☐
Pneumonia	☐	☐	Palpitation / pounding heart	☐	☐	Back pain / injury	☐	☐
Tuberculosis / lung disease	☐	☐	Pain / pressure in chest	☐	☐	Fractured / broken bones	☐	☐
Frequent bronchitis	☐	☐	High blood pressure	☐	☐	Swollen / stiff / painful joints	☐	☐
Shortness of breath	☐	☐	Diabetes	☐	☐	Amputations	☐	☐
Chronic cough	☐	☐	Stroke	☐	☐	Deformities of legs, feet, arms, hands, back or joints	☐	☐
Coughing up blood	☐	☐	Rheumatic fever	☐	☐	Loss of appetite	☐	☐
Sleep apnea / loud snoring	☐	☐	Bleeding disorder or issue	☐	☐	Unexplained weight change	☐	☐
Glasses / contacts	☐	☐	Inflammation of veins / clots	☐	☐	Tumors / abnormal growths	☐	☐
Glaucoma	☐	☐	Enlarged / varicose veins	☐	☐	Thyroid problems	☐	☐
Eye injury / operation / defects	☐	☐	Nausea / vomiting (frequent)	☐	☐	Hernia	☐	☐
Loss of hearing / ringing in ears	☐	☐	Vomiting up blood	☐	☐	Hemorrhoids	☐	☐
Headaches (frequent / severe)	☐	☐	Ulcer(s)	☐	☐	Venereal disease(s)	☐	☐
Head injury	☐	☐	Diarrhea (frequent / severe)	☐	☐	Allergies (drug, hay fever, food)	☐	☐
Blackouts / dizziness / fainting	☐	☐	Constipation (frequent / severe)	☐	☐	Currently taking medications	☐	☐
Epilepsy / seizures	☐	☐	Blood in bowel movement	☐	☐	Previous surgery(s)	☐	☐
Nervous disorders	☐	☐	Gallbladder trouble	☐	☐	Other illness or injury	☐	☐
Fear of heights	☐	☐	Kidney / bladder problems	☐	☐	Other: _____	☐	☐
Claustrophobia	☐	☐	Liver disease	☐	☐	Other: _____	☐	☐
Skin conditions	☐	☐	Cancer	☐	☐			

EXPLANATION OF ALL "YES" ANSWERS

_____

_____

LIFESTYLE & WORK HISTORY

	Y	N	IF YES
Current or former smoker	☐	☐	*Packs a day?* _____ *For how many years?* _____ *If former, how long ago did you quit?* _____
Do you drink alcoholic beverages?	☐	☐	*Drinks per week?* _____ *What type(s)?* _____
Have you ever had a drug or alcohol problem?	☐	☐	*Please explain:* _____

	Y	N	IF YES
Have you **ever** been injured at work?	☐	☐	*Please explain:* _____ *Company name & address:* _____
Have you **ever** received worker's comp benefits?	☐	☐	*Please list:* _____
Have you **ever** been placed on light duty from an injury?	☐	☐	*Please explain:* _____
Has any injury or illness left you with a physical limitation?	☐	☐	*Please explain:* _____

I understand that failure to answer truthfully may result in the denial of compensation benefits, including medical treatment and expenses. I hereby certify that the information provided above and the information which I will provide to the medical provider in connection with this examination is true and correct to the best of my knowledge. I understand that any omission of fact or false statement is sufficient grounds for denial of employment or, if employed, termination of my employment.

EMPLOYEE SIGNATURE _____

DATE _____