

Medical Surveillance Questionnaire

FORM MC-113

Complete every section. Answer for your entire work history, not only your current employer.

FIRST NAME _____		LAST NAME _____		SSN / EMPLOYEE ID _____	
DATE OF BIRTH _____	AGE _____	SEX ☐ Male ☐ Female	TODAY'S DATE _____		
EMPLOYER / COMPANY _____			JOB TITLE _____		

OCCUPATIONAL & PAST WORK HISTORY

Worked with asbestos, silica, or other dusts	☐ YES	☐ NO
Worked with lead, cadmium, arsenic, or other metals	☐ YES	☐ NO
Worked with benzene, solvents, or degreasers	☐ YES	☐ NO
Worked with pesticides or herbicides	☐ YES	☐ NO
Worked with radiation or radioactive material	☐ YES	☐ NO
Worked in confined spaces	☐ YES	☐ NO
Regular exposure to loud noise at work	☐ YES	☐ NO
Currently required to wear a respirator	☐ YES	☐ NO
Previous workplace injury or illness claim	☐ YES	☐ NO

If yes, explain: _____

FAMILY HISTORY

Heart disease before age 55	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Lung disease	☐ YES	☐ NO
Kidney disease	☐ YES	☐ NO

If yes, explain: _____

RESPIRATORY

Shortness of breath walking on level ground	☐ YES	☐ NO
Chronic cough or coughing up phlegm	☐ YES	☐ NO
Wheezing or chest tightness	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Chronic bronchitis or emphysema (COPD)	☐ YES	☐ NO
Tuberculosis or positive TB test	☐ YES	☐ NO
Pneumonia in the last 12 months	☐ YES	☐ NO
Currently smoke or use tobacco	☐ YES	☐ NO

If yes, explain: _____

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CARDIOVASCULAR

Chest pain or pressure with exertion	☐ YES	☐ NO
Heart attack, bypass, or stent	☐ YES	☐ NO
Irregular heartbeat or palpitations	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
High cholesterol	☐ YES	☐ NO
Swelling in ankles or legs	☐ YES	☐ NO
Blood clot in the leg or lung	☐ YES	☐ NO

If yes, explain: _____

MUSCULOSKELETAL

Back injury or chronic back pain	☐ YES	☐ NO
Neck injury or chronic neck pain	☐ YES	☐ NO
Shoulder, elbow, wrist, or hand problems	☐ YES	☐ NO
Hip, knee, ankle, or foot problems	☐ YES	☐ NO
Arthritis or joint swelling	☐ YES	☐ NO
Hernia, current or repaired	☐ YES	☐ NO
Difficulty lifting, climbing, or prolonged standing	☐ YES	☐ NO

If yes, explain: _____

GASTROINTESTINAL

Frequent heartburn or reflux	☐ YES	☐ NO
Stomach or duodenal ulcer	☐ YES	☐ NO
Persistent nausea, vomiting, or abdominal pain	☐ YES	☐ NO
Blood in stool or black stools	☐ YES	☐ NO
Chronic diarrhea or constipation	☐ YES	☐ NO

If yes, explain: _____

HEPATOBIILIARY & PANCREAS

Hepatitis A, B, or C	☐ YES	☐ NO
Jaundice or yellowing of skin or eyes	☐ YES	☐ NO
Gallbladder disease or gallstones	☐ YES	☐ NO
Pancreatitis	☐ YES	☐ NO
Abnormal liver function tests	☐ YES	☐ NO

If yes, explain: _____

CENTRAL NERVOUS SYSTEM

Seizures or epilepsy	☐ YES	☐ NO
Head injury with loss of consciousness	☐ YES	☐ NO
Frequent or severe headaches	☐ YES	☐ NO
Dizziness, fainting, or balance problems	☐ YES	☐ NO
Numbness, tingling, or weakness in arms or legs	☐ YES	☐ NO
Memory or concentration difficulty	☐ YES	☐ NO
Stroke or TIA	☐ YES	☐ NO

If yes, explain: _____

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HEMATOLOGIC

Anemia or low blood count	☐ YES	☐ NO
Bleeding or clotting disorder	☐ YES	☐ NO
Blood transfusion	☐ YES	☐ NO
Enlarged lymph nodes	☐ YES	☐ NO

If yes, explain: _____

SKIN

Rash, dermatitis, or eczema	☐ YES	☐ NO
Chemical burn or skin reaction at work	☐ YES	☐ NO
Chronic skin infection or ulcer	☐ YES	☐ NO
Skin cancer or suspicious mole	☐ YES	☐ NO

If yes, explain: _____

HEENT - HEAD, EYES, EARS, NOSE, THROAT

Vision problems not corrected by glasses	☐ YES	☐ NO
Hearing loss or ringing in the ears	☐ YES	☐ NO
Ear drainage or frequent ear infections	☐ YES	☐ NO
Chronic sinus problems or nosebleeds	☐ YES	☐ NO
Hoarseness or difficulty swallowing	☐ YES	☐ NO

If yes, explain: _____

GENITOURINARY

Kidney stones or kidney disease	☐ YES	☐ NO
Blood in urine	☐ YES	☐ NO
Frequent urinary tract infections	☐ YES	☐ NO
Difficulty or pain with urination	☐ YES	☐ NO
Currently pregnant or possibly pregnant	☐ YES	☐ NO

If yes, explain: _____

EMPLOYEE ATTESTATION & ELECTRONIC SIGNATURE CONSENT

I certify that the answers above are true and complete to the best of my knowledge. I understand that withholding information may affect the accuracy of my medical clearance and my fitness for duty. I agree that signing this form electronically has the same force and effect as a handwritten signature, and I consent to conduct this transaction by electronic means.

EMPLOYEE SIGNATURE

DATE

PROVIDER REVIEW

FINDINGS / FOLLOW-UP REQUIRED

PROVIDER SIGNATURE — ALEJANDRA FLORES, APRN, MSN, FNP-BC

DATE