Dignity Health.
Pacific Central Coast Health Centers
Med Plus

Medical History — Occupational Medicine

Name ______________________________ DOB ____________________

Company / Position ____

Medications ____

Drug Allergies ____

Last Tetanus ______________________________

Have you ever had or do you now have any of the following? (If yes, please describe below.)

	Yes	No		Yes	No
1. Anemia or blood disease			30. Head injury		
2. Heart trouble, rheumatic fever or murmur			31. Back injury, ruptured disc		
3. High blood pressure			32. Arthritis, bursitis		
4. Chest pain or angina			33. Bone or joint disease		
5. Shortness of breath			34. Sexually transmitted disease		
6. Frequent colds or persistent cough			35. Recent weight gain or loss		
7. Diseases of the lungs, asthma			36. Been denied employment for health reasons		
8. Allergy, hay fever			37. Been refused application for life insurance		
9. Eye trouble			38. Filed an industrial claim		
10. Deafness or ear trouble			39. Had health problems from exposure to chemicals		
11. Major illness			40. Handicaps or limitations		
12. Operations			41. Had problems from vibrating tools		
13. Skin disease or rash			42. Out of work more than a week due to injury/illness		
14. Varicose veins or leg sores			43. Been under the care of a doctor in the past year		
15. Cancer or tumors			44. Taken medication for several months or years		
16. Stomach or intestinal trouble			45. Been on street drugs or methadone program		
17. Liver, gall bladder problems, jaundice			46. Are you now taking drugs or medication		
18. Hemorrhoids, rectal bleeding			47. Do you smoke		
19. Hernia			48. Packs per day		
20. Diabetes			49. If no, have you ever smoked________ Number of years_______		
21. Thyroid problems			50. Do you drink alcoholic beverages		
22. Sugar or albumin in urine			51. How many drinks per day ______per week______		
23. Kidney or bladder trouble			52. Were you ever a heavy drinker or member of AA		
24. Frequent headaches or migraines			53. When		
25. Dizziness, fainting spell, epilepsy, fits					
26. Mental illness or nervousness					
27. Paralysis, nerve disease or injury					
28. Severe injury					
29. Broken bones					

For any questions that you answered yes please list the question numbers and indicate the following:

- Specify the injury/illness (i.e., broken right hand).
- Date of onset of injury/illness.
- Present condition of injury/illness (i.e., broken hand healed in 2010, no treatment received since).
- Treatment received for injury/illness (i.e., cast for broken hand).
- Any permanent restrictions related to injury/illness (i.e., hand fully healed no restrictions, or hand healed but I cannot lift more than 20 lbs. with right hand).
- If injury/illness is work related that information must be included.

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