

## Western Maryland Health System Employee Health Health History Questionnaire

Name _____		Male <input type="checkbox"/>	Female <input type="checkbox"/>	DOB _____	Age _____
Address _____		City _____		State _____	Zip _____
SS# _____			Race _____		
<u>Telephone Numbers</u>					
Home _____		Cell _____		Work _____	
Position applying for _____				Department _____	
Personal Physician _____					
Address _____		City _____		State _____	Zip _____
Next of kin or person to notify in case of emergency					
Name _____		Address _____		Phone _____	

What is your general state of health at this time?

Excellent       Good       Needs Improvement       Poor

**Family History:** (Please indicate if any member of your family has a history of the following medical conditions)

	Yes	No	Relationship		Yes	No	Relationship
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Tendencies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Back Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	_____	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genetic Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	_____	On-the-Job-Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other (Name)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Is your mother: Living  Deceased

Is your father: Living  Deceased

Cause of death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Age at time of death: \_\_\_\_\_

Age at time of death: \_\_\_\_\_

**Medical History: Have you had any of the following illnesses:**

Strep Throat	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Frequent Bladder Infections	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>
Polio	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Measles (2 wk)	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	Malaria	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	Herpes	<input type="checkbox"/>
Measles (Rubella – 3 day)	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	Mental Disorder	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	Back Trouble	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Other Heart Disease	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Frequent Lung Infections	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>
				Wrist-Hand Problems	<input type="checkbox"/>

Others (Describe): \_\_\_\_\_

Please comment on any checked illnesses (indicate date or age encountered and/or current status):

\_\_\_\_\_

\_\_\_\_\_

Serious injuries (indicate whether job related or not, date and description):

\_\_\_\_\_

List present medications you are taking and for what reason:

\_\_\_\_\_

Hospitalizations (give reason and dates – operations or other illnesses):

\_\_\_\_\_

Allergies to medications: Yes  No  If yes, please list: \_\_\_\_\_

Other allergies (i.e., foods, pollens, other materials):

\_\_\_\_\_

Latex allergy: Yes  No  If yes, please complete latex questionnaire.

Do you wear any prosthesis or special devises: Yes  No

If yes, please indicate appropriate item:

Ortho Braces  Special Shoes  Hearing Aid  Glasses  Contact Lenses

Other: \_\_\_\_\_

**Diagnostic: (Have you had any of the following tests? If so, when)**

	Yes	No	Date (M/D/Y)		Yes	No	Date (M/D/Y)
Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	Back X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	Electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	Spirometry (Breathing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hearing Test	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gall Bladder X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	TB Skin Test	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	Was TB test positive?	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	Were you treated with medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____				

**Immunizations: (Have you had any of the following vaccines? If so, when)**

	Yes	No	# of Doses	Date of Last Dose		Yes	No	# of Doses	Date of Last Dose
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Varicella	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
DPT- (Diphtheria/ Pertussis/ Tetanus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tetanus/ Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Have you ever had a blood transfusion: Yes  No  Date \_\_\_\_\_

**Social History: (Please mark appropriate item)**

Military Service: Yes  No  From \_\_\_\_\_ to \_\_\_\_\_ Years \_\_\_\_\_

Married  Single  Divorced  Widowed

Number of children: \_\_\_\_\_

Education:

Highest grade completed: \_\_\_\_\_

Degree earned: \_\_\_\_\_

Technical or trade school: \_\_\_\_\_

Consumption of alcohol: (Please mark appropriate item)

Hard Liquor: Yes  No  \_\_\_\_\_ Number of ounces/week

Wine: Yes  No  \_\_\_\_\_ Number of glasses/week

Beer: Yes  No  \_\_\_\_\_ Number of cans/week

If yes to hard liquor, specify brand/name: \_\_\_\_\_

Do you drink coffee, tea, or caffeinated soft drinks? Yes  No  Occasionally

Coffee cups/day \_\_\_\_\_ Tea cups/day \_\_\_\_\_ Soft drinks cups/day \_\_\_\_\_

Do you or have you ever smoked? Yes  No

Cigarette	Number/day	_____	For	_____	Years
Cigars	Number/day	_____	For	_____	Years
Pipe	Bowls/day	_____	For	_____	Years
Snuff/ Chewing Tobacco	Yes <input type="checkbox"/>	No <input type="checkbox"/>	For	_____	Years

If you have stopped smoking, when was it? \_\_\_\_\_

Have you ever used any of the following drugs? (Mark all that apply )

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Morphine  | <input type="checkbox"/> PCP                          |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Heroin                       |
| <input type="checkbox"/> Cocaine   | <input type="checkbox"/> Other (please specify) _____ |

Please explain any marked items: \_\_\_\_\_

**Occupational History**

1. Do you have any mental or physical disabilities which cause you to limit your activities?  
Yes  No
2. Have you ever had a back injury?  
Yes  No
3. Have you ever had a hernia?  
Yes  No
4. Have you ever had an injury that made you miss work?  
Yes  No
5. Have you ever had an illness that caused you to miss 10 or more days of work?  
Yes  No
6. Do you have any family members who work at a job that may involve exposure to materials they may bring home on their clothing?  
Yes  No
7. Do you live in an area near factories or other industry where you might be exposed to harmful substances?  
Yes  No
8. Have you ever been ill or sought medical attention after being exposed to a harmful substance?  
Yes  No
9. Have you ever had any problems with your hands, wrists or arms?  
Yes  No

Please explain all 'Yes' answers from the above questions; please number the responses with the number of their corresponding question:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list your hobbies or any other job activities you may be involved in:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list below your past jobs, starting with present or most recent

Company	Specific Job Description	Illness/ Injury on Job	Time Missed Due to Illness/ Injury	Did You File Worker's Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the outcome?
				Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the outcome?
				Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the outcome?
				Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the outcome?
				Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the outcome?

Please list below substances or environments you have been exposed to, on and off the job, and protective equipment used, i.e., respirators, gloves, hearing protection.

	At Work			Off Work		Protective Equipment Used
	Type	How Long	Company	Type	How Long	
Dust (other than household)						
Fumes/ Gases						
Chemicals						
Radiation/ UV						
Vibration						
Noise						
Asbestos						
Other						

## Review of Systems

Do you have any physical/mental disabilities? Yes  No

If yes, please describe: \_\_\_\_\_

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### A. General

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Do you worry a lot about your health?                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you usually feel tired or worn out?                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have you recently been drinking more water or fluids?          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Has there been an unusual weight gain or loss recently?        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you usually feel lonely or depressed?                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have a tendency to feel hot or cold?                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are there any swellings in your armpits or groin?              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have difficulty either falling asleep or staying awake? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you bruise easily?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If you get cut, do you heal quickly?                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

### B. Skin

Have you notice:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Any change in the color of your skin?     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any skin rashes or itching?               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Unusually dry skin?                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any growth on your skin that bothers you? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any sores or wounds that do not heal?     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any change in color or size of warts?     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any unusual lumps or swollen glands?      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

### C. Eyes

Have you had:

- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| Any pain in your eyes?          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Glaucoma?                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Blurry vision?                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Halos around lights?            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Change in vision?               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you wear contact lenses?     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you wear glasses?            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is your eyesight getting worse? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you ever see double?         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

### D. Ear, Nose & Throat

Do you have:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Any trouble hearing?                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Ringing or buzzing in your ears?               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sinus problems?                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chronic drainage down the back of your throat? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Drainage from your ears?                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Frequent or severe nosebleeds?                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Persistent hoarseness?                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| A lump in your throat?                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| A sore tongue or mouth?                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Bleeding gums?                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pain or difficulty swallowing?                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Dental problems? Yes  No

Any sore swellings on your gums or jaws? Yes  No

Have you had any earaches lately? Yes  No

Have you ever had a perforation of the ear drum? Yes  No

### E. Cardiovascular

Do you have any problems with your heart? Yes  No

Do you have any pain, tightness or pressure in the front or back of your chest? Yes  No

If yes, is it when walking fast, working hard, or when excited? Yes  No

Have you ever been told that your electrocardiogram was abnormal? Yes  No

Do you have pain in the leg muscles when you walk? Yes  No

Do you ever awaken at night with severe difficulty breathing? Yes  No

Do your fingers or toes get cold, become numb or get very white or bluish? Yes  No

Have you ever been told that you have a heart murmur? Yes  No

### F. Gastrointestinal

Have you recently had any change in your eating habits? Yes  No

Have you recently noted any trouble swallowing? Yes  No

Do you have a lot of indigestion or heartburn? Yes  No

Have you ever vomited blood? Yes  No

Are you bothered with constipation? Yes  No

Do you have frequent stools or diarrhea? Yes  No

Do you awaken at night with a feeling of fullness underneath your breast bone? Yes  No

Have you ever passed blood from your rectum? Yes  No

Have you ever had black or tarry stools? Yes  No

Have you noticed any recent changes in your bowel movements? Yes  No

Do you take laxatives regularly? Yes  No

Do you have frequent nausea and/or vomiting? Yes  No

Are your bowel movements ever light grey in color? Yes  No

### G. Respiratory

Do you have:

Frequent chest colds? Yes  No

A constant bothersome cough? Yes  No

Coughing of blood? Yes  No

Sputum or phlegm between colds? Yes  No

Difficulty breathing? Yes  No

Wheezing or whistling in your chest? Yes  No

Shortness of breath with mild to moderate activity? Yes  No

### H. Musculoskeletal

Do you have a problem with back pain? Yes  No

Do you have pain in your legs or feet? Yes  No

Does back pain interfere with your work or activities? Yes  No

Do you have joint pain, stiffness or swelling? Yes  No

Do you have trouble walking or using your hip or knee? Yes  No

Do you have pain in your wrists/hands or arms? Yes  No

### I. Central Nervous System

Do you have frequent or severe headaches? Yes  No

Do you have spells of dizziness, faintness, or lightheadedness? Yes  No

Do you see double? Yes  No

Do you ever lose track of what happens around you for a short time? Yes  No

Have you recently fainted, blacked out, or lost consciousness? Yes  No   
 Have you ever had convulsions or seizures? Yes  No   
 Do you have numbness or tingling in or arms, hands, legs, or feet? Yes  No

**J. Genitourinary**

Do you have:

Anything wrong with your genitals? Yes  No   
 Burning or pain when you urinate? Yes  No   
 To pass water frequently? Yes  No   
 Trouble passing water? Yes  No   
 To get up at night to urinate? Yes  No   
 Trouble with losing urine when you cough or sneeze? Yes  No   
 A problem dribbling urine? Yes  No

Men Only:

Do you have prostate gland trouble? Yes  No   
 Have you had burning or discharge from your penis? Yes  No   
 Are there any swellings or lumps on your testicles? Yes  No   
 Do your testicles get painful? Yes  No

Women Only:

Do you have severe menstrual pain? Yes  No   
 Are your menstrual periods irregular? Yes  No   
 Is your flow extremely heavy? Yes  No   
 Do you have vaginal discharge or itching? Yes  No   
 Have you experienced menopause? Yes  No   
     If yes, have you noticed any vaginal bleeding since? Yes  No   
 Do you ever have bleeding after intercourse? Yes  No   
 Have you had any discharge from your nipples? Yes  No   
 Have you noted any abnormal changes in your breasts? Yes  No   
 Are you now pregnant? Yes  No   
 Last pap smear Date \_\_\_\_\_  
 Last menstrual period Date \_\_\_\_\_

I certify that the answers given during this history and medical examinations are true, as far as I am aware.

I consent to this examination, by Western Maryland Health System designated physician or nurse practitioner as may be required.

I understand and agree that this examination is being performed in connection with my employment and that Western Maryland Health System shall have no obligation or responsibility, whatsoever, for treating or counseling me with respect to any condition found to exist.

I understand that falsification of the information contained in this questionnaire or material omission of fact will result in the cancellation of application for employment and if employed may be cause for immediate dismissal.

Signature: \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_