PROGRESSIVE HEALTHCARE GROUP

PRIMARY CARE PROVIDER
Michael R. Gray, M.D., M.P.H.

SCOPE OF PRACTICE

Internal Medicine
Family Practice
Emergency Medicine
Occupational Medicine
Industrial & Environmental Toxicology
Independent Medical Examiner

BOARD OF CERTIFICATION

Preventive Medicine
Occupational Medicine
Certified Independent Medical Examiner

SPECIAL SERVICES

Ambulatory Cardiac Monitoring
Pulmonary Function Testing
Cardiac Stress Testing
Cryotherapy of Skin Lesions

MEMBERSHIP

Cochise County Medical Society
Benson Ambulance Services Board of Directors
American Medical Association
American Public Health Association
Arizona Medical Association
Arizona Public Health Association
American Occupational Medical Association
American Society of Internal Medicine
Southern Arizona EMS Council

Contracted with major insurance Companies

Accepts Medicare and Industrial Commission Assignments

Medical Data Base
Strictly Confidential

Please fill out the attached questionnaire before you come to your appointment for your physical exam. Please do not hesitate to contact the office staff at Progressive Healthcare Group if you need help in completing this form.

P.O. Box 1819
Benson AZ 85602
(520) 586-9111

Michael R. Gray, M.D., M.P.H., C.I.M.E.
Medical Director
PROGRESSIVE HEALTHCARE GROUP

PATIENT IDENTIFICATION DATA

(Please print)

Last Name_____, **First Name**_____, **MI**_____,

D.O.B._____

Social Security Number_____ **Birthplace**_____

Ethnic Origin (Nationality/Race)_____ **Male** ☐
Female ☐

Street Address_____ **City & State**_____

Zip _____

Home Telephone_____

Employer_____ **Department**_____

Work Address_____ **City & State**_____

Zip _____

Work Telephone _____

Position Applied For_____

PERSON TO CONTACT IN CASE OF ILLNESS OR EMERGENCY

Last Name_____, **First Name**_____ **MI**_____ **Relationship** _____

Address_____ **City & State**_____

Zip_____

Home Telephone_____

Name:_____ CONFIDENTIAL

CONSENT to be EXAMINED

I, _____, the undersigned, hereby consent to be examined by Michael R. Gray, M.D., M.P.H., and/or other duty appointed health practitioners on his staff. I understand that this examination is designed to assess my general health status and my ability to safely carry out specific tasks and responsibilities likely to be required of me during the course of my employment in the position for which I am applying.

I further understand that Dr. Gray and/or his staff will maintain the medical information generated in this record in confidence, and I have been assured that neither he nor his staff will reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in my character of physical being unless he is required to do so by law, or unless it becomes necessary to protect my welfare or that of the community at large.

I do understand that in the event that I sustain, or claim to have sustained, a work-related injury or illness, that Dr. Gray may be required to provide information relevant to that condition and appearing in this record to specific interested parties, as provided for by law.

I understand that if any significant abnormalities are found during the course of this examination, I will be promptly notified of same, and that Dr. Gray and/or his staff will make recommendations to me regarding appropriate follow up.

If I am disqualified from the position for which I am applying for medical reasons, I will be informed of the reasons for such disqualification, if I so request.

Signed: _____ Date: _____

Witnessed: _____ Date: _____

Name:_____

CONFIDENTIAL

COMPREHENSIVE MEDICAL HISTORY

In the following categories, please check the box for any illness or condition you have ever had in the past, and circle the box of any illness or condition you have now.

CHILDHOOD ILNESSES

- ☐ Arthritis
- ☐ Chorea
- ☐ Chicken pox
- ☐ Rheumatic Fever
- ☐ Hyperactivity
- ☐ Learning disabilities
- ☐ Dyslexia
- ☐ German measles (Rubella/3-day measles)
- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Ear infections
- ☐ Hemophilia
- ☐ Sickle Cell Disease/Trait

Other:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

MEDICAL ILLNESSES – ADULT AND CHILD

- ☐ Allergies
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder trouble
- ☐ Bleeding disorder
- ☐ Bowel disorder
- ☐ Bronchitis
- ☐ Bursitis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Eczema
- ☐ Emotional Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye infections
- ☐ Ear infections
- ☐ Glaucoma
- ☐ Genetic Disorder
- ☐ Gout
- ☐ Heart disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ Hives/Rashes
- ☐ Kidney Disease
- ☐ Liver disease
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Neuralgia
- ☐ Neuritis
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Rheumatism
- ☐ Tension/anxiety
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Yellow Jaundice
- ☐ Ulcers
- ☐ Skin
- ☐ Stomach
- ☐ Duodenal

Other:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please explain: Give dates, duration of illness, and name of treating physician:

_____
_____
_____
_____
_____
_____
_____

Name:_____

CONFIDENTIAL

MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below. (Please do not include normal pregnancies).

☐ Check here if you have had more than three such hospitalizations.

Year	Operation or Illness	Name of Hospital	City/State

INJURIES OR ACCIDENTS

Please check below if you have ever sustained:

☐ Major traumatic injuries requiring medical attention.
If so, please explain:

_____
_____
_____
_____

☐ A work-related injury.
If so, please explain:

_____
_____
_____
_____

☐ An injury involving your head, neck or back.
If so, please explain:

_____
_____
_____
_____

TESTS AND IMMUNIZATIONS

Please check the boxes for those that you have had. Enter the year in which you were last given the test or "shots."

- ☐ 19__ Chest x-ray
- ☐ 19__ Kidney x-ray
- ☐ 19__ G.I. series
- ☐ 19__ Colon x-ray
- ☐ 19__ Gallbladder x-ray
- ☐ 19__ Electrocardiogram
- ☐ 19__ TB test
- ☐ 19__ Other: _____
- ☐ 19__ Other: _____
- ☐ 19__ Smallpox "shots"
- ☐ 19__ Tetanus "shots"
- ☐ 19__ Polio series
- ☐ 19__ Typhoid "shots"
- ☐ 19__ Flu injections
- ☐ 19__ Mumps "shots"
- ☐ 19__ Measles "shots"
- ☐ 19__ Other: _____
- ☐ 19__ Other: _____

Name:_____

CONFIDENTIAL

MEDICINES

Please check those that you are now taking, and those that you are sensitive or allergic to:

Taking	Allergic	Taking	Allergic
☐	☐ Antibiotics	☐	☐ Aspirin
☐	☐ Penicillin	☐	☐ Diet Pills
☐	☐ Sulfa	☐	☐ Antacids
☐	☐ Opiates/Codeine	☐	☐ Laxatives
☐	☐ Sedatives	☐	☐ Cold tablets
☐	☐ Diuretics/Water pills	☐	☐ Other:_____
☐	☐ Stimulants/Caffeine	☐	☐ Other:_____
☐	☐ Demerol	☐	☐ Other:_____
☐	☐ Blood pressure medication	☐	☐ Other:_____

REPRODUCTIVE HISTORY

WOMEN:

How many pregnancies have you had? _____

How many of these pregnancies were:

- Carried to term? _____
- Medically terminated? _____
- Delivered prematurely? _____
- Miscarried? _____

How many live births have you had?

- Boys? _____
- Girls? _____

Did you experience complications:	Yes	No
During pregnancy?	___	___
During delivery?	___	___
Immediately following delivery?	___	___
Were any of your children born with birth defects, learning disabilities or developmental disabilities?	___	___
Did you experience diabetes during pregnancy?	___	___
Are you now pregnant?	___	___

If so, what is the estimated date of conception? _____

If you answered "yes" to any of the above, please explain:

_____

_____

_____

Name:_____ CONFIDENTIAL

REPRODUCTIVE HISTORY continued

		Yes	No
Men:	Do you have children?	☐	☐
	Were any of your children born with any Birth defects, learning disabilities or developmental disabilities?	☐	☐

I If you answered "yes" to either of the above, please explain:

_____

_____

_____

_____

_____

GENERAL MEDICAL QUESTIONS

	Yes	No
Have you ever been refused life insurance for medical or health reasons?	☐	☐
Have you ever been denied employment for health reasons?	☐	☐
Were you ever disqualified for military service for health or medical reasons?	☐	☐
Have you had to stop working for health reasons?	☐	☐

If you answered "yes" to any of the above, please explain: _____

_____

_____

_____

_____

Have you ever received a blood transfusion?	☐	☐
If so, were there any complications?	☐	☐

What is your blood type? _____

Please provide the following information regarding your weight:

Current _____ Maximum _____ Minimum (since age 18) _____

Please provide the following information regarding previous physical examinations:

Physician	Date(appropriate)	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name:_____ CONFIDENTIAL

PSYCHIATRIC HISTORY

	Yes	No
Have you ever been treated for a psychiatric illness?	☐	☐
Have you ever participated in psychological counseling?	☐	☐

If you answered "yes to either of the above, please explain: _____

_____

_____

_____

SOCIAL HISTORY

Current residence: ☐ House ☐ Townhouse ☐ Apartment ☐ Modular mobile ☐ Own ☐ Rent

How many persons, if any share your current residence? _____

Lifestyle and habits:

	Cigarettes		Pipe, Cigars, or Non-tobacco Cigarettes	
	Yes	No	Yes	No
Have you ever smoked?	☐	☐	☐	☐
Do you now smoke?	☐	☐	☐	☐
How many do/did you smoke per day on the average?	_____		_____	
At what age did you first start to smoke regularly?	_____		_____	
At what age did you stop smoking regularly?	_____		_____	
At what age did you stop smoking permanently?	_____		_____	
How many years have you smoked? (include years you may have quit)	_____		_____	

Coffee Use?

About how many cups of coffee containing caffeine do you drink daily? _____

Drug use or Addictions

	Yes	No
Have you ever been addicted to any drug?	☐	☐
If so, what drug? _____		
Was the drug prescribed by a physician?	☐	☐

Name:_____ CONFIDENTIAL

SOCIAL HISTORY Continued

Alcohol Use

Do you drink beverages containing alcohol? Yes ☐ No ☐

How often?

☐ Once or twice/year	Hard Liquor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 6	☐ More than 6
☐ Once or twice/month	Beer (cans/bottles)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 6	☐ More than 6
☐ Once or twice/week	Wine (glasses)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 6	☐ More than 6
☐ Regularly/daily							

Educational Background

Did you attend pre-school as a child? Yes/No If so, number of years:_____

How many years of elementary school did you complete? _____

How many years of junior high and high school did you complete? _____

How many years of college or junior college did you complete? _____

Name of college: _____

What educational degrees have you received?

☐ High School Diploma ☐ Doctorate
☐ B.A. ☐ Others:
☐ B.S. _____
☐ Master's _____

Did you receive formal technical training? Yes/No If so, in what field(s):

_____

_____

Marital Status

☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Name:_____ CONFIDENTIAL

FAMILY HISTORY

For each family member below, mark the box which indicates their present state of health, or the cause of their death. Also, check the boxes for any illnesses that they have ever had. If you are married, print the names of your spouse and children in the spaces provided.

	State of Health		or	Cause of Death
	Good	Poor	Deceased	
Father:	☐	☐	☐	_____
Mother:	☐	☐	☐	_____
Brothers:	☐	☐	☐	_____
Sisters:	☐	☐	☐	_____

Father:

☐ Alcoholism	☐ Diabetes	☐ Heart Trouble
☐ Allergies/Asthma	☐ Epilepsy	☐ High blood pressure
☐ Anemia	☐ Genetic Disease	☐ Kidney/Bladder Trouble
☐ Arthritis	☐ Glaucoma	☐ Nervous Breakdown
☐ Bleeds Easily	☐ Gout	☐ Rheumatism
☐ Cancer/Tumor		☐ Stomach/Duodenal Ulcer

Mother:

☐ Alcoholism	☐ Diabetes	☐ Heart Trouble
☐ Allergies/Asthma	☐ Epilepsy	☐ High blood pressure
☐ Anemia	☐ Genetic Disease	☐ Kidney/Bladder Trouble
☐ Arthritis	☐ Glaucoma	☐ Nervous Breakdown
☐ Bleeds Easily	☐ Gout	☐ Rheumatism
☐ Cancer/Tumor		☐ Stomach/Duodenal Ulcer

Brother:

Alcoholism	Diabetes	Heart Trouble
Allergies/Asthma	Epilepsy	High blood pressure
Anemia	Genetic Disease	Kidney/Bladder Trouble
Arthritis	Glaucoma	Nervous Breakdown
Bleeds Easily	Gout	Rheumatism
Cancer/Tumor		Stomach/Duodenal Ulcer

Sister:

Alcoholism	☐ Diabetes	☐ Heart Trouble
☐ Allergies/Asthma	☐ Epilepsy	☐ High blood pressure
☐ Anemia	☐ Genetic Disease	☐ Kidney/Bladder Trouble
☐ Arthritis	☐ Glaucoma	☐ Nervous Breakdown
☐ Bleeds Easily	☐ Gout	☐ Rheumatism
☐ Cancer/Tumor		☐ Stomach/Duodenal Ulcer

Name:_____ CONFIDENTIAL

FAMILY HISTORY Continued

	State of Health			or	Cause of Death
	Good	Poor	Deceased		
Spouse	☐	☐	☐		_____
Child:	☐	☐	☐		_____
Child:	☐	☐	☐		_____
Child:	☐	☐	☐		_____
Child:	☐	☐	☐		_____
Child:	☐	☐	☐		_____

Spouse:

Alcoholism		Diabetes	Heart Trouble
Allergies/Asthma		Epilepsy	High blood pressure
Anemia		Genetic Disease	Kidney/Bladder Trouble
Arthritis		Glaucoma	Nervous Breakdown
Bleeds Easily	Gout	Rheumatism	
Cancer/Tumor			Stomach/Duodenal Ulcer

Children:

Alcoholism		Diabetes	Heart Trouble
Allergies/Asthma		Epilepsy	High blood pressure
Anemia		Genetic Disease	Kidney/Bladder Trouble
Arthritis		Glaucoma	Nervous Breakdown
Bleeds Easily	Gout	Rheumatism	
Cancer/Tumor			Stomach/Duodenal Ulcer

Name:_____ CONFIDENTIAL

OCCUPATIONAL HISTORY SCREEENING QUESTIONNAIRE

The Occupational Health Screening Questionnaire used by Michael R. Gray, M.D., M.P.H., was developed by Seth Foldy, M.D. while he was a senior medical student at Case-Western Reserve University and represents one of the best screens for past and present occupational exposures that may have significant health impact. This history is used for the pre-employment database.

Some jobs can affect your health. If you and your doctor can recognize health risks in advance, illness may be prevented. To help your doctor detect job-related health hazards, please fill out this form as completely as possible. As the receptionist for help if you need it.

THIS WILL BE PART OF YOUR CONFIDENTIAL MEDICAL RECORD AND MAY ONLY BE RELEASED WITH YOUR WRITTEN PERMISSION

CURRENT STATUS

1. I am currently
   - ☐ Employed ☐ Full-time ☐ Part-time
   - ☐ Temporarily laid off
   - ☐ Retired
   - ☐ Disabled
   - ☐ Unemployed

If you are currently unemployed, please go directly to question 21 on page 16

CURRENT EMPLOYMENT

2. Please list any part-time, full-time, temporary or military jobs:

Job Title (type of work)	Employer and City	Date Started	Hours/Week (incl. overtime)

PHYSICIANS NOTES

CURRENT EXPOSURES

3. Please check the appropriate item if you are exposed to any of the following at your current job(s). Include exposures from other nearby workstations.

	Yes	Not Sure	Physician's Notes
a. Dusty Workplace	☐	☐	
b. Asbestos *(see below)	☐	☐	
c. Rock dusts (including sandblasting, foundry molds concrete, mine/ore dusts	☐	☐	
d. Vegetable dusts (including sawdust, cotton dust and flours	☐	☐	
e. Metal dusts (example: grinding)	☐	☐	
f. Molten metals or metal fumes	☐	☐	
g. Welding/acetylene torch	☐	☐	
h. Machine or cutting oils	☐	☐	
i. Solvents/degreasers/cleaning fluids	☐	☐	
j. Paints/varnishes/coatings	☐	☐	
k. Plastic/rubber/polymer chemicals	☐	☐	
l. Gasoline/other fuels	☐	☐	
m. Corrosives (acids or alkalis)	☐	☐	
n. Insect, rodent or weed killers	☐	☐	
o. Other chemical liquids or vapors	☐	☐	
p. Gases (used, produced, or by-products)	☐	☐	
q. Smoke (from burning materials	☐	☐	
r. Engine exhaust or carbon monoxide	☐	☐	
s. Loud noise	☐	☐	
t. Vibrations (example: air hammer)	☐	☐	
u. Extremes of heat or cold	☐	☐	
v. Long-term standing	☐	☐	
w. Heavy lifting	☐	☐	
x. Repetitive motions all day	☐	☐	
y. Video Display Terminal (VDT)	☐	☐	
z. Job stress ("pressure")	☐	☐	
aa. Infections or infectious materials	☐	☐	
bb. X-ray/direct radiation	☐	☐	
cc. Radioactive materials	☐	☐	
dd. Infrared/ultraviolet/laser	☐	☐	

*Asbestos mining, milling, textiles, brake linings, or repair, insulation, (especially pipes), ship building, cement manufacture, construction, electrical utility, or power plant worker.

4. Do you work with any materials that you believe or were told were harmful? Yes ☐ No ☐

If so, please list: _____

_____

_____

Name:_____ CONFIDENTIAL

WORKPLACE HYGIENE AND HABITS

	Yes	No
5. Do any materials at work frequently get on your skin or in the air you breath?	☐	☐

If so, please list: _____

6. Have you ever been exposed to unusually large amounts of hazardous materials at work, for example, accidents, spills, or fires? ☐ ☐

If so, please describe: _____

_____

7. Has an Industrial Hygieniest ever measured exposure to hazards at your job?	☐	☐
8. Do you smoke cigarettes, cigars, or a pipe?	☐	☐
If so, do you smoke at work?	☐	☐
9. Do you eat or drink in the same room in which you work?	☐	☐
10. Are your work clothes cleaned at work?	☐	☐
Are showers suggested by your employer before you return home?	☐	☐
11. Do you drink more than 2 beers or alcoholic beverages a day?	☐	☐
Do you drink at or before work?	☐	☐

PERSONAL PROTECTION

12. Have you ever been advised to use protective equipment at your current job? (check which)

	Yes	No	I use the equipment: As advised	Sometimes	Never
a. Goggles	☐	☐	☐	☐	☐
b. Hearing protection	☐	☐	☐	☐	☐
c. Respirator or face mask	☐	☐	☐	☐	☐
d. Ventilation hood/fan/suction	☐	☐	☐	☐	☐
e. Gloves	☐	☐	☐	☐	☐
f. Protective apron or suit	☐	☐	☐	☐	☐
g. Barrier cream (for skin)	☐	☐	☐	☐	☐
h. Other:_____	☐	☐	☐	☐	☐
i. Other:_____	☐	☐	☐	☐	☐

Name:_____ CONFIDENTIAL

SYMPTOMS/HEALTH PROBLEMS

13. Have you had any of these problems while employed at your present job(s)?

	Now	Past	Never	For Physician Use V	N/V	Additional History
a. Weight loss (without dieting)	☐	☐	☐	☐	☐	
b. Skin rash	☐	☐	☐	☐	☐	
c. Cracked, itchy skin	☐	☐	☐	☐	☐	
d. Vision problems	☐	☐	☐	☐	☐	
e. Hearing loss (incl. temporary)	☐	☐	☐	☐	☐	
f. Ringing or noise in ears	☐	☐	☐	☐	☐	
g. Itchy eyes, nose, throat	☐	☐	☐	☐	☐	
h. Frequent bloody nose	☐	☐	☐	☐	☐	
i. Strange taste in mouth	☐	☐	☐	☐	☐	
j. Shortness of breath	☐	☐	☐	☐	☐	
k. Tightness in chest	☐	☐	☐	☐	☐	
l. Asthma (wheezing)	☐	☐	☐	☐	☐	
m. Cough a lot	☐	☐	☐	☐	☐	
n. Heart disease	☐	☐	☐	☐	☐	
o. Stomach cramps (cause unknown)	☐	☐	☐	☐	☐	
p. Nausea/vomiting	☐	☐	☐	☐	☐	
q. Constipation	☐	☐	☐	☐	☐	
r. Yellow jaundice/liver disease	☐	☐	☐	☐	☐	
s. Blood in urine	☐	☐	☐	☐	☐	
t. Birth defects/miscarriages (both sexes, please answer)	☐	☐	☐	☐	☐	
u. Sexual problems	☐	☐	☐	☐	☐	
v. Back pain	☐	☐	☐	☐	☐	
w. Arthritis/joint pain	☐	☐	☐	☐	☐	
x. Anemia/ weak blood	☐	☐	☐	☐	☐	
y. Sleepiness or dizziness	☐	☐	☐	☐	☐	
z. Frequent headaches	☐	☐	☐	☐	☐	
aa. Irritability/depression	☐	☐	☐	☐	☐	
bb. Tremor/shakiness	☐	☐	☐	☐	☐	
cc. Numbness or "pins and needles"	☐	☐	☐	☐	☐	
dd. Muscle weakness	☐	☐	☐	☐	☐	
ee. Sleep problems	☐	☐	☐	☐	☐	
ff. Coordination difficulties	☐	☐	☐	☐	☐	

Name:_____ CONFIDENTIAL

SYMPTOMS/HEALTH PROBLEMS

	Yes	No
14. Do you have any health problems that you think are caused by or made worse by your job?	☐	☐
If so, please describe: _____		
15. Do you have symptoms (for example, cough or dizziness) that appear mainly at work?	☐	☐
16. IF YOU ANSWERED YES TO QUESTIONS 14 AND 15: do these symptoms occur?		
a. Increasingly as the work day or week goes on?	☐	☐
b. Especially worse at the beginning of the work week?	☐	☐
c. Especially worse after work?	☐	☐
17. Do other workers in your workplace complain of job-related health problems?	☐	☐
If so, please describe: _____		
18. On your current job(s) did you receive a pre-employment physical examination?	☐	☐
19. Do you receive any regular physical examinations or testing (hearing tests, blood tests, x-rays) on the job?	☐	☐
If so, please describe: _____		

REPRODUCTIVE STATUS (Women)

20. Are you:		
a. between 15-45 years of age?	☐	☐
b. planning a child in the future?	☐	☐

Name:_____ CONFIDENTIAL

EMPLOYMENT HISTORY

21. Please list your past jobs in order from the first to the most recent. Include all full-time, part-time, temporary and military jobs.

Job title (type of work)	Employer and City	Date Started	Hours/Week (incl. overtime)

PHYSICIAN'S NOTES

PAST EXPOSURES

22. Please check the box if you have ever been exposed to, or worked, with the following:

- ☐ Asbestos*
- ☐ Silica**
- ☐ Cotton dust
- ☐ Coal dust
- ☐ Beryllium
- ☐ Arsenic
- ☐ Mercury
- ☐ Lead
- ☐ Nickel
- ☐ Chromium
- ☐ Chromates
- ☐ Insect killers
- ☐ Plant killers
- ☐ Chemical dyes
- ☐ Solvents/degreasers
- ☐ Coke oven fumes
- ☐ Tars/pitch/soot
- ☐ Rubber manufacture
- ☐ Vinyl chloride
- ☐ PCB's
- ☐ Chemical manufacture
- ☐ Radiation/radioactive material
- ☐ Plastic/polymer manufacture

* Mining, milling, textiles, insulated pipes, brake linings/repair, shipbuilding and some cements.

** Dust from sandblasting, foundry molds, stone cutting/carving, mining dusts, silica flours, diatomaceous or Fuller's earth, talc, some cements.

Name:_____ CONFIDENTIAL

PAST ILLNESS/INJURY HISTORY

	Yes	No
23. Have you ever had any injuries or illnesses related to work? If so, please describe (include which job and treating physician): _____	☐	☐
24. Have you ever applied for Worker's Compensation?	☐	☐

HOME AND NEIGHBORHOOD EXPOSURES

25. Does anyone else in your household currently work? If so, please state job title: _____	☐	☐
26. Please list your hobbies: _____		
27. Do you use chemicals (cleaning solutions, insect killers, etc.) around your home? If so, please list: _____	☐	☐
28. Are there features in your neighborhood which you feel may be a threat to health (for example a factory, pollution, dumps)? If so, please describe:	☐	☐

Name:_____ CONFIDENTIAL

COMPREHENSIVE SYSTMS HEALTH QUESTIONNAIRE

The following questions represent a systematic review of symptoms which you have experienced within the last year, or which you may currently be experiencing. These questions are designed to assist the examining physician or health practitioner to recognize salient symptoms associated with each organ system or anatomic region of your body.

INSTRUCTIONS: Please answer all the questions by checking 'yes' or 'no'. For each symptom or condition you are now experiencing, please note any relevant factors, such as how often the symptom occurs, how long it lasts when it does occur, what, if anything causes the symptom to occur, and what things you might do to achieve relief from the symptom.

GENERAL

	Yes	No	
1. Are you subject to weakness or excessive fatigue?	___	___	_____
2. Do you experience profuse sweating during the night?	___	___	_____
3. Are you subject to fever or chills?	___	___	_____
4. Has there been any weight change greater than 10 pounds?	___	___	_____
5. Is your appetite good?	___	___	_____

SKIN, NAILS, and HAIR

1. Do you have any chronic skin diseases?	___	___	_____
2. Any sores that will not go away?	___	___	_____
3. Do you have any lumps, rashes, or excessive itching?	___	___	_____
4. Any areas where you skin has turned color other than from tanning?	___	___	_____
5. Any problems with nail brittleness, infections, pitting or ridging?	___	___	_____
6. Any hair abnormalities or disease?	___	___	_____
7. Is your skin excessively sensitive to soaps, detergents or chemicals?	___	___	_____

BLOOD DISEASES/ANEMIA

1. Do you have a history of leukemia, lymphoma or Hodgkin's disease?	___	___	_____
2. Do you have persistent swollen glands?	___	___	_____
3. Are you subject to easy bruising or excessive bleeding?	___	___	_____
4. Have you had sever bleeding after surgery or a dental procedure?	___	___	_____
5. Are you anemic?	___	___	_____

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HEAD, EYES, EARS, NOSE and THROAT

	Yes	No	
1. Do you have frequent or severe headaches?	___	___	_____
2. Have you had any head injuries or concussions?	___	___	_____
3. Are you subject to dizziness, vertigo or fainting spells?	___	___	_____
4. Do you have seizures or epilepsy?	___	___	_____
5. Do you wear glasses or contacts?	___	___	_____
6. When was your last visual examination?	___	___	_____
7. Have you had a recent visual change?	___	___	_____
8. Do you have normal color vision?	___	___	_____
9. Have you experienced double vision, "tunnel vision" or persistent blurring?	___	___	_____
10. Do you have glaucoma or other serious eye disease?	___	___	_____
11. Do you have pain, itching or inflammation of your eyes?	___	___	_____
12. Can you hear normal conversation?	___	___	_____
13. Do you have recurrent earaches?	___	___	_____
14. Do you have a hearing loss?	___	___	_____
15. Is there a buzzing or ringing in your ears?	___	___	_____
16. Do you have chronic stuffy or runny nose or sinus?	___	___	_____
17. Do you have severe or recurrent nose bleeds?	___	___	_____
18. Do you have seasonal or chronic allergies?	___	___	_____
19. If so, are they severe enough to cause loss of work?	___	___	_____
20. Do you have dental disease or problems with teeth or gums?	___	___	_____

21. When was your last dental exam? Date:_____ Dentist:_____

22. Do you grit or grind your teeth?	___	___	_____
23. Do you have sores in your mouth or on your tongue?	___	___	_____
24. Do you have dentures?	___	___	_____
25. Do you have difficulty chewing or swallowing your food?	___	___	_____
26. Do you have frequent or chronic sore throat?	___	___	_____
27. Is your voice hoarse?	___	___	_____
28. Is there any history of thyroid disease?	___	___	_____
29. Have you had radiation to your neck or chest for thyroid or thymus enlargement?	___	___	_____

BREASTS

1. Have you had any breast disease or surgery?	___	___	_____
2. Do you examine your breasts regularly?	___	___	_____
3. Have you had any breast discharge or bleeding?	___	___	_____

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CHEST and LUNGS

	Yes	No	
1. Do you have asthma, wheezing or emphysema?	___	___	_____
2. Have you ever had a "collapsed lung?"	___	___	_____
3. Do you have a chronic cough?	___	___	_____
4. Do you cough up phlegm (thick mucous) or blood?	___	___	_____
5. Are you subject to shortness of breath or wheezing with minor exertion?	___	___	_____
6. Have you had pneumonia or other serious lung disease?	___	___	_____
7. Have you previously been skin tested for tuberculosis or valley fever (coccidioidomycosis)?	___	___	_____
8. Have you had any chest injury?	___	___	_____

HEART and CARDIOVASCULAR

1. Do you have any heart condition or disease?	___	___	_____
2. Do you have pain, pressure, or heavy sensation in your chest?	___	___	_____
3. Does your heart "race" (other than after exercise) or beat irregularly?	___	___	_____
4. Do you have high blood pressure?	___	___	_____
5. Do your legs swell?	___	___	_____
6. Do you sleep on more than two pillows?	___	___	_____
7. Do you wake up at night short of breath?	___	___	_____
8. Is there any history of inflammation of the veins (phlebitis)?	___	___	_____
9. Do you have circulation problems?	___	___	_____
10. Have you had episodes of weakness of one side (or arm or leg), slurred speech, (not due to alcohol or medication)?	___	___	_____
11. Do your hands turn excessively blue, cold or painful during cold weather?	___	___	_____

STOMACH and INTESTINES

1. Do you have ulcers, gastritis, colitis or other chronic bowel conditions?	___	___	_____
2. Has there been a change in your bowel habits; i.e. more constipation or diarrhea?	___	___	_____
3. Have you ever committed blood or coffee-ground-like material?	___	___	_____
4. Do you have pain or blood with bowel movements?	___	___	_____
5. Have you had yellow jaundice, hepatitis, or pancreatitis?	___	___	_____
6. Do you have a "nervous stomach" or irritable or spastic colon?	___	___	_____
7. Do you regularly take laxatives or antacids?	___	___	_____
8. Do you have a hernia?	___	___	_____

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GENITOURINARY

	Yes	No	
1. Do you have burning or pain on urination?	___	___	_____
2. Do you have to urinate more than twice during the night, or more than six times during the day?	___	___	_____
3. Have you noticed pus, blood or solid material in your urine?	___	___	_____
4. Have you passed a kidney stone?	___	___	_____
5. Have you had syphilis, gonorrhea, genital herpes, or other genitourinary infection?	___	___	_____
6. If you are sexually active; are your sexual contacts predominantly with members of the same sex? (Note: This question is asked because of differences in disease susceptibility).	___	___	_____

WOMEN:

1. How old were you when your periods began? AGE: _____
2. Do you still have periods? ___ ___ _____
   if so, are they regular? ___ ___ _____

if no, when did they cease? _____

3. Do you have vaginal discharges? ___ ___ _____
4. Do you have severe pain or heavy bleeding with menstruation? ___ ___ _____
5. Do you have pain with intercourse? ___ ___ _____
6. Do you have bleeding not associated with your periods? ___ ___ _____
7. If you are sexually active, what form of contraception do you use:
   ___ Birth control pills ___ IUD
   ___ Diaphragm ___ Condom
   ___ Rhythm ___ None
8. When was your last Pap smear? _____
9. Do you have stress incontinence? ___ ___ _____

MEN:

1. do you have difficulty starting or stopping urination? ___ ___ _____
2. Do you have difficulty having an erection? ___ ___ _____
3. Do you have discharge; fluid or blood from the penis? ___ ___ _____
4. Do you have testicle pain or swelling? ___ ___ _____

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MUSCULOSKELETAL

	Yes	No	
1. Do you have severe muscle pain or cramps not proportional to exercise?	___	___	_____
2. Do you have red, swollen joints, arthritis or severe joint pain?	___	___	_____
3. Do you have joint stiffness or "frozen" joints?	___	___	_____
4. Do you have loss of mobility due to fracture or other injury?	___	___	_____

NEUROLOGIC

1. Do you suffer from paralysis or permanent weakness of an extremity?	___	___	_____
2. Do you have a tremor or other involuntary movement?	___	___	_____
3. Do you have numbness or diminished sensation?	___	___	_____
4. Do you have difficulty with coordination, clumsiness, or slurred speech?	___	___	_____
5. Have you had any neurologic or brain disease or injury?	___	___	_____

ENDOCRINE

1. Do you experience excessive thirst and urination?	___	___	_____
2. Do you have intolerance to heat or cold?	___	___	_____
3. Have you noticed a change in skin pigmentation, shoe or glove size?	___	___	_____

PSYCHOLOGICAL

1. Are you frequently depressed?	___	___	_____
2. Have you been depressed to the point of considering suicide?	___	___	_____
3. Are you excessively nervous?	___	___	_____
4. Do you have difficulty sleeping?	___	___	_____
5. Have you experienced hallucinations?	___	___	_____
6. Do you have difficulty controlling your temper?	___	___	_____
7. Do you have difficulty getting along with others?	___	___	_____
8. Do other people at work frequently cause problems for you?	___	___	_____

I hereby certify that the answers to the questions in the foregoing questionnaires are true and accurate to my knowledge and recollection.

_____ _____

Signature **Date**

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