MEDICINE of THE HIGHEST ORDER

Strong Employee Health (EH)

Pre-Health Assessment Screening

Name (print): ____________________________________ Today's date: _________________________________

Age: ____ Date of Birth: _________________________ Gender: Male _____ Female _____

Job title / type of work: ____

Medical History

1. List all medications that you take on a routine or periodic basis (include over-the-counter medications, vitamins, and supplements): ____
____

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2. List all allergies (including drugs, environmental, & latex): ____
____

3. List all current or active medical problems for which you see a physician or other health care provider:
____
____

4. List all past hospitalizations and operations (includes dates):
____
____
____

5. Current restrictions:
   Has a health professional told you to limit your activities at home or work?
   No ☐ Yes ☐
   Do you have any permanent medical restrictions on your activities or any permanent impairments?
   No ☐ Yes ☐
   Do you need any accommodations to perform the job for which you are being evaluated?
   No ☐ Yes ☐

Social History

Do you use tobacco products? No ☐ Yes ☐
If yes, number of packs / dips per day ______ and number of years ______
Do you drink alcohol? No ☐ Yes ☐
If yes, how much do you drink on an average week ___________________

Occupational History

List past employment, providing the information requested below:

Company name Job / Position Dates Workplace Exposures

1. ____
2. ____
3. ____
4. ____

OVER →

Review of systems: Have you ever had or do you currently have any of the following (check [x] for each item)

Past = past medical problem

Current = current medical problem

Please explain any "Yes" answers (Past or Current) in the space provided below. ↓

	No	If Yes: Past	Current
1. Frequent / severe fatigue	☐	☐	☐
2. Arthritis / bursitis / tendonitis	☐	☐	☐
3. Carpal tunnel syndrome	☐	☐	☐
4. Back / spine trouble	☐	☐	☐
5. Amputations / bone – joint problem	☐	☐	☐
6. Cancer	☐	☐	☐
7. Diabetes / sugar problems	☐	☐	☐
8. Skin problems	☐	☐	☐
9. High / low blood pressure	☐	☐	☐
10. Chest pains / palpitations	☐	☐	☐
11. Heart trouble	☐	☐	☐
12. Anemia	☐	☐	☐
13. Difficulty breathing	☐	☐	☐
14. Chronic cough or sputum	☐	☐	☐
15. Asthma or emphysema	☐	☐	☐
16. Pneumonia	☐	☐	☐
17. Tuberculosis	☐	☐	☐
18. Past positive test for TB	☐	☐	☐
19. Abdominal pain	☐	☐	☐
20. Bowel / stomach problems	☐	☐	☐
21. Stomach / duodenal ulcers	☐	☐	☐
22. Liver / gallbladder disease	☐	☐	☐
23. Jaundice (turning yellow)	☐	☐	☐
24. Hernias or ruptures	☐	☐	☐
25. Urinary problems	☐	☐	☐
26. Menstrual problems	☐	☐	☐
27 Infertility	☐	☐	☐
28. Fainting episodes	☐	☐	☐
29. Convulsions / epilepsy	☐	☐	☐
30. Severe head injuries	☐	☐	☐
31. Dizziness / lightheadedness	☐	☐	☐
32. Severe headaches	☐	☐	☐
33. Change in vision	☐	☐	☐
34. Change in hearing	☐	☐	☐
35. Psychiatric conditions	☐	☐	☐

The Genetic Information Nondiscrimination Act *(GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Patient/Examinee Signature: ________________________________ Date: ______________

☐ Review Completed by OEM nurse.

☐ Deferred to OEM Provider for Focused Exam.

Nurse Reviewer Signature: _________________________________ Date: ______________

Provider Signature: _______________________________________ Date: ______________