OLMSTED MEDICAL CENTER
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Occupational and Health History

This information is needed in accordance with OSHA standards.

Occupational and Health History
Surveillance or Periodic Exam

Name: _____ Date of Birth: _____ Pt ID: _____

Employer: _____ Date: _____

Current Occupational History
Describe current job responsibilities as well as chemical and environmental exposures (include actual and potential exposures):

_____

_____

Describe any personal protective equipment you use, or could potentially use, on your job including respirators (types), gloves, goggles, eyewear, hearing protection, etc.:

_____

_____

_____

Past Exposure
Have you ever used or been exposed to (please check):

- ❑ arsenic
- ❑ asbestos
- ❑ benzene
- ❑ beryllium
- ❑ cadmium
- ❑ carbon tetrachloride
- ❑ chromates
- ❑ ethylene chloride
- ❑ fluorides
- ❑ formaldehyde
- ❑ loud noises
- ❑ mercury or other heavy metal
- ❑ pesticides
- ❑ phenols
- ❑ phosgene
- ❑ PVC's
- ❑ radioactive materials
- ❑ solvents/degreasers
- ❑ sprays/paints
- ❑ trichlorethylene
- ❑ welding/soldering
- ❑ others (list): _____

Please explain source, amount, and time frame related to above exposures:

_____

_____

_____

_____

Have you ever received medical surveillance (periodic check-ups or tests) as part of a previous job?

❑ Yes ❑ No Explain: _____

Please indicate which of the following types of personal protective equipment you have used on previous jobs:

- ❑ Respirators
- ❑ Hearing Protection
- ❑ Gloves
- ❑ Protective Clothing
- ❑ Safety glasses/goggles
- ❑ Other (list): _____

Surveillance/Periodic Health History

Name: _____ DOB: _____ Pt ID: _____

Have you had or do you now have unexplained or persistent:	Yes	No
General weight loss or decreased appetite	☐	☐
Skin rash or irritation	☐	☐
Difficulty remembering, concentrating, or sleeping / Confusion	☐	☐
Dizziness, lightheadedness, weakness, or fatigue	☐	☐
Headaches	☐	☐
Nervousness, irritability, anxiety, or depression	☐	☐
Trembling, numbness, tingling, or weakness in hands, feet, or other parts of the body	☐	☐
Metallic taste in your mouth	☐	☐
Abdominal pain, indigestion, heartburn	☐	☐
Nausea, vomiting, diarrhea, or constipation	☐	☐
Bloody or tarry-black stools	☐	☐
Jaundice (Yellowing of your skin) or dark colored urine	☐	☐
Fever or chills	☐	☐
Swollen or tender lymph nodes	☐	☐
Lump or thickening anywhere on your body	☐	☐
Bruising or discoloration of skin	☐	☐
Abnormal blood loss or bleeding from nose, mouth, gums	☐	☐
Irritation, redness, burning, or itching of eyes / visual problems	☐	☐
Urinary burning, urgency, frequency or retention	☐	☐
Coughing, wheezing, or shortness of breath	☐	☐
Chest pain, irregular or fast heart beat, or swelling of feet or ankles	☐	☐
Muscle, joint, or back pain	☐	☐
Fertility problems or child born with birth defect	☐	☐
Leukemia / Cancer	☐	☐
Liver disease	☐	☐
Neurological disorder / Seizures	☐	☐
Hyper or hypo thyroidism	☐	☐
Diabetes or High Blood Sugar	☐	☐
Asthma, bronchitis, or emphysema	☐	☐
Kidney or bladder disease	☐	☐
Hypertension (high blood pressure) or heart disease	☐	☐
MALES: Prostate gland problems	☐	☐
FEMALES: Menstrual difficulties or irregularities	☐	☐

List medications you are currently taking: _____

_____

_____

Social History

Have you ever used tobacco? ☐ Yes ☐ No If yes, currently use? ☐ Yes *(amount per day and # of years: _____)*
☐ No *(quit date: _____)*

Do you eat at the work-site? ☐ Yes ☐ No

Are separate eating facilities provided at the worksite? ☐ Yes ☐ No

Employee/Patient Signature: _____ Date: _____

Reviewer's Comments: _____

_____

_____

Clinician Signature: _____ Date: _____