WellNow OCC MED
Occupational Health Questionnaire

Name:	Age:	Sex: ☐ Male	☐ Female
Address:	City:	State:	Zip:
Birth Date:	SS# or ID#:	Company:	
Job Position:		Can you read? ☐ Yes / ☐ No	

1. To discuss this questionnaire, contact your WELLNOW OCC MED location.

2. Phone no. where the reviewing doctor may reach you to discuss this questionnaire: ☐ AM or ☐ PM( )

3. Any allergies to: Latex ☐ Yes / ☐ No **Medications** ☐ Yes / ☐ No **(please list): Other:**

4. Immunization History: (check box and list year if known)

☐ Td ☐ Tdap ☐ Polio ☐ Hepatitis A ☐ Mumps ☐ Influenza
☐ Pneumonia ☐ Rubella ☐ PPD ☐ Hepatitis B ☐ Measles
☐ Small Pox

5. Family History ☐ Stroke ☐ Cancer ☐ High Blood Pressure ☐ Tuberculosis ☐ Diabetes ☐ Heart Disease ☐ Bleeding
Other

6. Work related history of injury or occupational disease? ☐ YES ☐ NO

7. Have you had work restrictions due to injury or illness? ☐ YES ☐ NO

8. List history of hospitalizations and reason why:

9. Are you currently being treated for an illness or disease? If yes, please explain and share the name of your medical provider. ☐ YES ☐ NO

10. Current medications:

11. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ YES ☐ NO
If yes, how much each day? What did you smoke?
How long have/did you smoked? # of years Date you quit?
Have you ever taken a smoking cessation class? ☐ YES ☐ NO
Do you drink alcohol on a regular basis? If yes, how much and what?
Any current or past history of illicit drug use? ☐ YES ☐ NO **If yes, how much and what?**
Have you ever participated in a Substance Abuse Professional (SAP) program? ☐ YES ☐ NO
If yes, where and when?

12. Have you ever had any of the following conditions?

Seizures (fits): Date of last seizure: Current meds:	☐ YES	☐ NO
Diabetes: Controlled by: ☐ Diet ☐ Pills ☐ Insulin ☐ Other Injectables	☐ YES	☐ NO
Frequent headaches?	☐ YES	☐ NO
Unintentional weight loss?	☐ YES	☐ NO
Loss of appetite?	☐ YES	☐ NO

13. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	☐ YES	☐ NO
Asthma Current Meds: Time/date of last dose?	☐ YES	☐ NO

	Chronic bronchitis	☐ YES	☐ NO
	Emphysema	☐ YES	☐ NO
	Pneumonia Dates:	☐ YES	☐ NO
	Tuberculosis Dates:	☐ YES	☐ NO
	Silicosis	☐ YES	☐ NO
	Pneumothorax (collapsed lung) Dates:	☐ YES	☐ NO
	Broken ribs Dates:	☐ YES	☐ NO
	Any chest injuries or surgeries Dates:	☐ YES	☐ NO
14.	**Do you currently have any of the following symptoms of pulmonary or lung illnesses?**		
	Shortness of breath	☐ YES	☐ NO
	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ YES	☐ NO
	Shortness of breath when walking with other people at an ordinary pace on level ground	☐ YES	☐ NO
	Have to stop for breath when walking at your own pace on level ground	☐ YES	☐ NO
	Shortness of breath when washing or dressing yourself	☐ YES	☐ NO
	Shortness of breath that interferes with your job	☐ YES	☐ NO
	Wheezing	☐ YES	☐ NO
	Wheezing that interferes with your job	☐ YES	☐ NO
	Chest pain when you breathe deeply	☐ YES	☐ NO
15.	**Have you ever had any of the following cardiovascular or heart symptoms?**		
	Heart attack Dates:	☐ YES	☐ NO
	Stroke Dates:	☐ YES	☐ NO
	Angina Medications:	☐ YES	☐ NO
	Heart failure Date:	☐ YES	☐ NO
	Swelling in your legs or feet (not caused by walking)	☐ YES	☐ NO
	Heart arrhythmia (heart beating irregularly) Medications:	☐ YES	☐ NO
	High blood pressure Medications:	☐ YES	☐ NO
16.	**Have you ever had any of the following cardiovascular or heart symptoms?**		
	Frequent pain or tightness in your chest	☐ YES	☐ NO
	Pain or tightness in your chest during physical activity	☐ YES	☐ NO
	Pain or tightness in your chest that interferes with your job	☐ YES	☐ NO
	Heart skipping or missing a beat (in the past 2 years)	☐ YES	☐ NO
	Heartburn or indigestion that is not related to eating	☐ YES	☐ NO
17.	**Have you ever had any of the following gastrointestinal problems?**		
	Heartburn or indigestion	☐ YES	☐ NO
	Ulcer disease	☐ YES	☐ NO
	Hepatitis or jaundice	☐ YES	☐ NO
	Cirrhosis of the liver	☐ YES	☐ NO
	Red blood or dark tarry stools, or chronic diarrhea and/or constipation?	☐ YES	☐ NO
18.	**Have you ever had any of the following problems?**		
	Eye irritation	☐ YES	☐ NO
	Skin allergies or rashes	☐ YES	☐ NO
	Anxiety	☐ YES	☐ NO
	General weakness or fatigue	☐ YES	☐ NO
	Kidney or bladder stones or problems with urination	☐ YES	☐ NO

19.	**Have you ever lost vision in either eye (temporarily or permanently):**	☐ YES	☐ NO
	Wear contact lenses	☐ YES	☐ NO
	Wear glasses	☐ YES	☐ NO
	Color blind	☐ YES	☐ NO
	Any other eye or vision problem: Please list:	☐ YES	☐ NO
20.	**Have you ever had any injury to your ears, including a broken ear drum?**	☐ YES	☐ NO
21.	**Do you currently have any of the following hearing problems?**		
	Difficulty hearing	☐ YES	☐ NO
	Wear a hearing aid: ☐ Right ☐ Left ☐ Both	☐ YES	☐ NO

22.	**Have you ever had a back injury? Dates:**	☐ YES	☐ NO
23.	**Do you currently have any of the following musculoskeletal problems?**		
	Weakness in any of your arms, hands, legs, or feet	☐ YES	☐ NO
	Difficulty with moving your hands, dexterity or grip strength	☐ YES	☐ NO
	Back pain	☐ YES	☐ NO
	Back surgery Dates:		
	Difficulty fully moving your arms and legs	☐ YES	☐ NO
	Pain or stiffness when you lean forward or backward at the waist	☐ YES	☐ NO
	Difficulty fully moving your head up or down	☐ YES	☐ NO
	Difficulty fully moving your head side to side	☐ YES	☐ NO
	Issues with neck pain	☐ YES	☐ NO
	Difficulty bending at your knees	☐ YES	☐ NO
	Difficulty squatting to the ground	☐ YES	☐ NO
	Difficulty climbing a flight of stairs or a ladder while carrying more than 25 pounds:	☐ YES	☐ NO
	Any other muscle or skeletal problems?	☐ YES	☐ NO
24.	**Do you have any current psychiatric issues?**	☐ YES	☐ NO
25.	**Do you currently take medication for any of the following problems?**	☐ YES	☐ NO
	Breathing, trouble sleeping or lung problems	☐ YES	☐ NO
	Heart trouble	☐ YES	☐ NO
	Blood pressure	☐ YES	☐ NO
	Seizures	☐ YES	☐ NO
26.	**Have you ever had cancer? If yes, what kind:**	☐ YES	☐ NO
27.	**Do you have any metal plates, screws, rods etc. within your body?**	☐ YES	☐ NO

I certify that the above answers are true and correct to the best of my knowledge.

Employee Signature: _____ Date: _____

Examiners review of above questionnaire:

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WellNow Occupational Medicine

_____
(Provider's Printed Name)

_____ _____ Expires on _____
(Provider's Signature) Date