CT OCCUPATIONAL MEDICINE PARTNERS

☐ **St Francis / Hartford**
Tel: 860-714-4270
FAX: 860-714-8068

☐ **St. Francis / Windsor**
Tel: 860-714-9444
FAX: 860-714-8900

☐ **St. Francis / Torrington**
Tel: 860-482-3467
FAX: 860-482-3867

☐ **MedWorks/Bristol**
Tel: 860-589-0114
FAX: 860-589-1936

☐ **MedWorks/Newington**
Tel: 860-667-4418
FAX: 860-667-1503

☐ **CorpCare / S Windsor**
Tel: 860-647-4796
FAX: 860-644-0287

☐ **Corporate Health Care / Danbury**
Tel: 203-749-5720
FAX: 203-739-1881

☐ **Johnson Memorial / Enfield**
Tel: 860-763-7668
FAX: 860-763-7676

OCCUPATIONAL HEALTH
WORK, ENVIRONMENT AND HEALTH QUESTIONNAIRE

Name: _____ Social Security #_____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date of Birth: _____

Cell Phone:_____Today's Date: _____

Email:_____

Employer Name:_____

How would you prefer to be contacted for reminders? (please **circle** preference below)

1.TEXT 2.EMAIL 3.PHONE (HOME or CELL)

OCCUPATIONAL HISTORY

List every place where you have been employed for more than six (6) months back to your first job, starting with your current or most recent job.

Start Mo/Yr	End Mo/Yr	Employer City, State	Type of Business	Job Title	Job Duties	Exposures

Hobbies:_____

Have you ever worn a respirator at work? Yes _____ No _____
Were you able to perform your job with a respirator on? Yes _____ No _____

Have you ever:

Filed a Worker's Compensation Claim or received benefits as a result of a work related injury or illness?
Yes _____ No _____
Experienced overexposure to or ill effects from chemical exposure? Yes _____ No _____
Received a disability settlement or a permanent impairment rating? Yes _____ No _____
Do you work at another job? Yes _____ No _____

Please explain all Yes answers:_____
_____
_____

Patient Name: _____

IMMUNIZATION HISTORY

Please provide a written record signed by your physician with dates for the following vaccinations, illnesses, or tests. If you cannot provide these, you will be tested for immunity to these diseases.

Measles (rubeola): Date of illness _____ Date of immunization: #1 _____ #2 _____

Date of lab test: _____ Result: _____

Rubella (German measles): Date of illness _____

Date of immunization: #1 _____ #2 _____

Date of lab test: _____ Result: _____

Please provide the dates for the following where applicable:

	Immunization	Lab titer result	Illness	Comment
Chicken Pox				
Mumps				
Diphtheria/Tetanus				
Hepatitis B				
TB skin test/BCG				
Polio				
Rabies				

SMOKING AND ALCOHOL USE

Have you ever smoked cigarettes regularly? Yes _____ No _____

If yes, do you still smoke? Yes _____ No _____

When did you quit smoking? (Date) _____

How many years have you smoked, or if you no longer smoke, how many years did you smoke? _____ yrs.

On the average, how many packs per day do you smoke, or if you no longer smoke, how many did you smoke? _____ packs per day.

Have you ever smoked a pipe or cigars regularly? Yes _____ No _____

Have you ever been a regular consumer of beer or other alcohol? Yes _____ No _____

FAMILY PHYSICIAN

Name: _____

Address: _____

Telephone Number _____ Date last seen by a physician: _____

Are any other physicians currently treating you? Yes ____ No ____

If yes, please write their name, address and telephone number:

_____

_____

Patient Name: _____

MEDICAL HISTORY

Current Medications: _____

_____

Allergies to medications and other substances: _____

_____

Do you wear contact lenses? Yes _____ No _____

Have you ever been in the hospital? Yes _____ No _____

If yes, when, where, and why? _____

_____

_____

Do you have or have you ever had any of the following:

	No	Yes	Date of Onset	If yes, please detail
ARTHRITIS, RHUMATIC FEVER				
BLOODDISORDER, INCLUDING ANEMIA				
LIVER DISEASE, INCLUDING HEPATITIS				
SKIN CONDITION				
MISCARRIAGE (SELF OR PARTNER)				
INFERTILITY, CHILD WITH BIRTH DEFECT				
TUBERCULOSIS				
ULCERS, OTHER STOMACH OR BOWEL DISEASE				
GALL BLADDER DISEASE				
DISORDER OF BONES OR MUSCLES				
FRACTURES				
THYROID PROBLEMS				
DIABETES				
KIDNEY DISEASE				
PROBLEMS W/PERPHERAL NERVOUS SYSTEM (WEAKNESS, NUMBNESS)				
RUPTURE OF EARDRUM, HEARING LOSS				
CANCER OR TUMOR (TYPE)				
EPILEPSY (SEIZURES)				
BACK INJURY, PAIN OR TROUBLE				
MENTAL ILLNESS OR BREAKDOWN				
LUNG CONDITIONS (BRONCHITIS, EMPHYSEMA, PNEUMONIA, ASTHMA, BLOOD CLOT IN LUNGS)				
INJURIES TO OTHER BODY PARTS				
HEART DISEASE, INCLUDING HYPERTENSION				
OTHER CONDITIONS				
DATE OF LAST EYE EXAM				

I attest that the information contained on this three page Medical History questionnaire is truthful and complete to the best of my knowledge.

Patient Signature: _____ **Date:_____**

If you are under 18 years of age, guardian signature is required

Provider Signature:_____ **Date:_____**