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

Last Name: ____First ___________________________________

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 appointment reminders? (Please check preference below)

☐ TEXT ☐ EMAIL ☐ HOME PHONE ☐ CELL PHONE

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 any YES, please explain
Arthritis, Rheumatic Fever				
Blood Disorder (including Anemia)				
Liver Disease (including Hepatitis)				
Skin Condition				
Miscarriage (Self or Partner)				
Infertility, Child with Birth Defect				
Tuberculosis				
Ulcers, Other Stomach of Bowel				
Gall Bladder Disease				
Disorder of Bones or Muscles				
Fractures				
Thyroid Problems				
Diabetes				
Kidney Disease				
Problems w/Peripheral 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, Asthma, Pneumonia, Blood Clots 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. ***Note: If you are under 18 years of age, guardian signature is required.***

Patient Signature: ____ **Date:**______________________

Provider Signature:____ **Date:**______________________

Please email the completed form to corpcare@echn.org prior to your scheduled appointment.