



STAMBUSH STAFFING

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your employee health file.

Name <i>(Last, First, M.I.)</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Doctor Name & Number:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
List any medical problems that a doctor has diagnosed:		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital
Have you ever received a blood transfusion?		<input type="checkbox"/> Yes <input type="checkbox"/> No
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT CONFIDENTIAL

Exercise	<input type="checkbox"/> Sedentary (No exercise)
	<input type="checkbox"/> Mild exercise (i.e. climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 minutes)
	<input type="checkbox"/> Regular vigorous exercise (i.e. work or recreation 4x/week for 30 minutes)
Diet	Are you dieting <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day? _____
	Rank salt intake <input type="checkbox"/> High <input type="checkbox"/> Med <input type="checkbox"/> Low
	Rank fat intake <input type="checkbox"/> High <input type="checkbox"/> Med <input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind? <input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you concerned about the amount you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes- packs/day _____ <input type="checkbox"/> Chew- #/day _____ <input type="checkbox"/> Pipe- #/day _____ <input type="checkbox"/> Cigars- #/day _____
	<input type="checkbox"/> # of years <input type="checkbox"/> or year quit _____
Drugs	Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No

Print Employee Name: _____

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Maternal</i>		
<input type="checkbox"/> M		Grandmother			
<input type="checkbox"/> F		<i>Paternal</i>			
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Paternal</i>			

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.		
<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/ Neck	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	<input type="checkbox"/> Carpal Tunnel

By signing below you certify that the statements listed above are true and accurate.

Employee Signature: _____ Date: _____

Employee (printed): _____

Reviewed by MRO: _____ Date: _____