

**US PUBLIC HEALTH SERVICE
FEDERAL OCCUPATIONAL HEALTH
MEDICAL HISTORY**

A comprehensive history is an important part of your medical record. Please complete this confidential questionnaire as accurately as possible by placing a check mark (✓) in the appropriate spaces and by printing other information as requested.

DATE: _____

1. IDENTIFICATION

- Sex: Male Female
 Check One: Black (non-Hispanic) Hispanic White (non-Hispanic) Asian Pacific Islander American Indian/Alaskan Native

LAST NAME	FIRST (No nickname)	MIDDLE	SURNAME (at birth)
SOCIAL SECURITY NO.		BIRTHDATE	PLACE OF BIRTH: Country State City
AGENCY/DEPT.	BLDG & RM.	WORK PHONE	WORK EMAIL ADDRESS
WORK ADDRESS		CITY, STATE	ZIP
JOB TITLE		SUPERVISOR	SUPERVISOR'S TELEPHONE NO.
EMERGENCY CONTACT PERSON		RELATIONSHIP	TELEPHONE NO.
PRIMARY PHYSICIAN		PHYSICIAN'S ADDRESS	PHYSICIAN'S TELEPHONE NO.
HOME MAILING ADDRESS		CITY, STATE ZIP	HOME TELEPHONE NO.
EMAIL ADDRESS			

2. MEDICATIONS

Which of the following do you take more than once a week: None

- | | |
|---|---|
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Ibuprofen (Advil/Motrin) |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Insulin/diabetic pills |
| <input type="checkbox"/> Antihistamines/allergy pills | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Stomach/intestinal pills |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Blood pressure pills | <input type="checkbox"/> Tranquilizers/sedatives |
| <input type="checkbox"/> Decongestants/cold pills | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Heart medication | <input type="checkbox"/> Weight reduction pills |
| <input type="checkbox"/> Hormones | |

List medications (prescription and non-prescription) that you currently take:

3. IMMUNIZATIONS

Have you received the hepatitis B vaccine? Yes No

If "yes" number of shots? 1 2 3 year completed _____

Year of last tetanus/Tdap booster _____

If born after 1956, date of last measles booster _____

4. ALLERGIES

To which of the following are you allergic:

- None
 Drugs (specify below) Pollens Food
 Dust or Molds Animal Other (specify below)

5. MEDICAL HISTORY (check the one that applies)

Which of the following conditions have you ever had?
 Enter year of diagnosis, if known, or check box if unknown:

- _____ Head injury
- _____ Migraines
- _____ Seizures
- _____ Stroke
- _____ Glaucoma
- _____ Cataracts
- _____ Thyroid trouble
- _____ Diabetes
- _____ High blood pressure
- _____ High cholesterol or triglycerides
- _____ Heart murmur
- _____ Rheumatic fever
- _____ Heart attack
- _____ Pneumonia
- _____ Asthma
- _____ Emphysema
- _____ Positive skin test for TB
- _____ Active tuberculosis
- _____ Ulcers
- _____ Hepatitis
- _____ Gall stones
- _____ Bladder infections
- _____ Kidney stones
- _____ Arthritis
- _____ Gout
- _____ Herniated disc
- _____ Sexually transmitted infection
- _____ Anemia
- _____ Tumors
- _____ Cancer
- _____ Depression/anxiety

Other medical/psychiatric disorders—please, specify:

US PUBLIC HEALTH SERVICE
FEDERAL OCCUPATIONAL HEALTH
HEALTH RISK APPRAISAL (BASIC)

Please help us provide the best care targeted to your specific health status by answering the following questions. Understanding the impacts of health risk factors allows us, as well as you, to take action to protect and improve your health. Carefully read each statement and print the information requested or place a check mark (✓) in the appropriate space(s). Choose the answer that is right most of the time. **All information is protected under the Federal Privacy Act.**

6. BIOMETRICS (to be performed by provider)

BMI: Height _____ Weight _____ BMI _____
BP: _____ / _____

7. PHYSICAL ACTIVITY (Complete all that apply)

A. In a typical week, how many minutes do you engage in vigorous activity? (e.g., jogging or running, swimming laps, riding a bike fast or uphill, playing basketball, etc.)

_____ MINS (in 10-minute intervals)

B. In a typical week, how many minutes do you engage in moderate activity? (e.g., walking fast, water aerobics, pushing a lawnmower, riding a bike on level ground, etc.)

_____ MINS (in 10-minute intervals)

(To be performed by provider)

Physical Activity Index (for Combined Activity Only)

(Moderate min. × 3.0) + (Vigorous min. × 7.5) =

_____ *Mets-min.*

8. HEALTHY EATING (check the one that applies)

During the past month, would you describe your eating habits as:

Healthy Moderately healthy Not very healthy Unhealthy

9. TOBACCO USE (check the one that applies)

Have you ever smoked or used tobacco? Yes No

If "yes", when: Current Past—years since quitting _____

Type: cigarettes cigar pipe other (please specify) _____

How much per day? _____ For how many years? _____

10. STRESS (check the one that applies)

A. During the last month, how much stress have you experienced:

A lot Moderate amount Relatively little Almost none

B. In the past year, how much effect has stress had on your health?

A lot Some Hardly any or none

11. ALCOHOL USE (please circle the appropriate response)

	0	1	2	3	4
A). During a typical week, how many standard drinks containing alcohol do you consume?	Never use alcohol	Less than 1/week	1 to 6 / week	1 to 2/day (7-14/week)	More than 2/day
B). Thinking back over the past month, how many times (if any) have you had five or more drinks on one occasion?	None	Once	Twice	Three to five times	Six times or more

12. MOOD / DEPRESSION (check the one that applies)

Over the past 2 weeks, how often have you been bothered by any of the following:

a). Little interest or pleasure in doing things Not at all Several days More than half the days Nearly every day

b). Feeling down, depressed, or hopeless Not at all Several days More than half the days Nearly every day

Staff Use Only

Risk(s) Identified <i>(circle all that apply)</i>	Risk Def	Counsel Provided		Referral		Referral Type (please specify)
Body Mass Index	≥ 30	Yes	No	Yes	No	
Physical Activity (mins/week)	Moderate ≤ 150 Vigorous ≤ 20 Comb ≤ 450 (Mets)	Yes	No	Yes	No	
Tobacco Use	Currently smokes / currently uses tobacco	Yes	No	Yes	No	
Healthy Eating	not very healthy <u>or</u> unhealthy	Yes	No	Yes	No	
Stress	A lot (one or more responses)	Yes	No	Yes	No	
Alcohol Use	Total score of 4 or more for men Total score of 3 or more for women and men over age 65	Yes	No	Yes	No	
Depressive Symptoms	Total score of 3 <u>or</u> Answering anything other than “not difficult at all” for last question	Yes	No	Yes	No	
Blood Pressure	Systolic ≥ 120 mm/Hg Diastolic ≥ 80 mm/Hg	Yes	No	Yes	No	
Cholesterol	Total ≥ 200 mg/dL HDL ≤ 40 mg/dL LDL ≥ 100 mg/dL Trig ≥ 160 mg/dL	Yes	No	Yes	No	
Glucose (fasting)	Fasting ≥ 110 mg/dL	Yes	No	Yes	No	
Other _____		Yes	No	Yes	No	

NOTES: _____

Follow-up:

Date: _____ **Risk(s) Addressed:** BMI PA Tobacco Healthy Eating Stress
Other(s) _____ Blood Pressure Cholesterol Glucose
Intervention: Counsel Referral

NOTES: _____

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