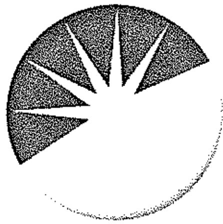
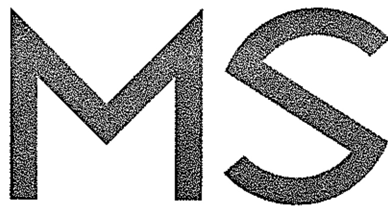



Medical Surveillance Questionnaire

Date: ____________________ Employer:______________________________________

Name: ____ Date of Birth:____________________

Work History

Present Job Title: __________________________ Dates of Employment:______________

Prior Job Titles	*Employer*	*Dates of Employment*	*Hazardous Material Exposure*

Have you ever had a work related illness or injury? ☐ No ☐ Yes; If Yes, please list details & dates:

____

____

Family History: Indicate any blood relative who have or have had any of the following:

Disease	Mother	Father	Grand-parents	Sibling	Child
Alcoholism	☐	☐	☐	☐	☐
Allergy	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Congenital Disorder	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Mental Disease	☐	☐	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐

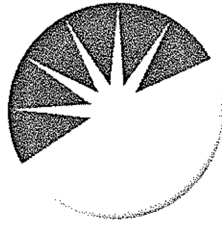
If either of your parents are deceased, list age and cause of death:

Mother: Age: __________ Cause of Death:______________________________________

Father: Age: __________ Cause of Death: ______________________________________

Are you aware of any illnesses that run in your family? ☐ No ☐ Yes; if yes, please list:

____



OMS OCCUPATIONAL MEDICAL SERVICES

Your Partner in Employee Health

Social History

Do you drink alcoholic beverages? □ Yes □ No

If yes, please answer the following questions:

How many beers do you drink each week? _________

How many glasses of wine do you drink each week? _______

Do you drink more than a fifth of hard liquor each week? ________

Do you currently smoke? □ Yes □ No

If no, are you a former smoker? □ Yes □ No

How long since you quit? _______

How many years did you smoke? ______

How much did you smoke per day? ______

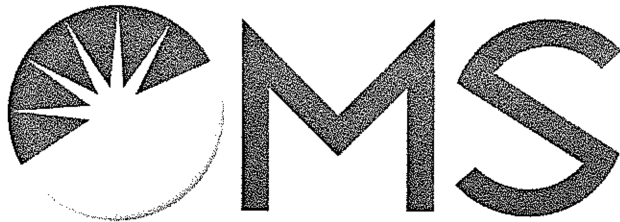
If yes, how long have you smoked? _________

How much do you smoke per day? ______

What do you smoke? (please circle) Cigarettes Cigars Pipe Tobacco

Exposure History : Have you ever been exposed to any of the following chemical agents?

- □ Acetic Acid
- □ Acetone
- □ Acetylene
- □ Alkalis
- □ Alkyl Chloride
- □ Ammonium Persulfate
- □ Antimony
- □ Asbestos
- □ Bacteria or viruses
- □ Benzene
- □ Beryllium
- □ Boron Trichloride
- □ Carbon Disulfide
- □ Chlorates
- □ Chlorinated Hydrocarbons
- □ Chlorine
- □ Chlorosilanes
- □ Coke Oven Emissions
- □ Crystalline Silica
- □ Cyanide
- □ Ethylene Glycol
- □ Excessive Noise
- □ Fluorine, Hydrazine
- □ Fluorocarbons
- □ Formaldehyde
- □ Helium
- □ Lead
- □ Lindane (Cotton Industry)
- □ Mercury
- □ Methanol
- □ Methyl Bromide
- □ Methyl Ethers
- □ Methylene Chloride
- □ Nitric Acid
- □ Nitrogen Oxide
- □ Nitrous Oxide
- □ Organic Arsenic
- □ Organic Peroxides
- □ Oxalic Acid
- □ PCB's
- □ Pesticides
- □ Petroleum Products
- □ Phosgene
- □ Phosphoric Acid
- □ Phosphorus Oxychlordie
- □ Primate Animals
- □ Silicon Tetrachloride Acid
- □ Sulfuric
- □ Suphur Dioxide
- □ Suspected/Known Carcinogens
- □ TDI
- □ Tolulene
- □ Tolulene Diisocynate
- □ Toxapenes
- □ Trichloroethane
- □ Vinyl Chloride
- □ Xylene



OCCUPATIONAL MEDICAL SERVICES
Your Partner in Employee Health

Past Medical History

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

- ☐ Abnormal Bleeding
- ☐ Allergies
- ☐ Anemia
- ☐ Ankle Weakness
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood in Urine
- ☐ Bone/ Joint Deformity
- ☐ Bowel Problems
- ☐ Cancer
- ☐ Chest Pains
- ☐ Chronic Cough
- ☐ Cirrhosis of the Liver
- ☐ Claustrophobia
- ☐ Cold/ Painful Fingers
- ☐ Constipation
- ☐ Dental/Gum Problems
- ☐ Depression/ Worry
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Difficulty Sleeping
- ☐ Elbow Trouble
- ☐ Epilepsy/Seizures
- ☐ Eye Trouble/Injury
- ☐ Fainting/Unconsciousness
- ☐ Fertility Problems
- ☐ Fever
- ☐ Dizziness
- ☐ Edema in foot/ leg
- ☐ Foot Trouble
- ☐ Frequent Indigestion
- ☐ Frequent/Severe Headaches
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Hair Loss
- ☐ Hay Fever
- ☐ Hearing Loss
- ☐ Heart Trouble
- ☐ Hemorrhoids
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives
- ☐ Leg Cramps
- ☐ Leukemia
- ☐ Liver Problems
- ☐ Loss of Memory
- ☐ Malaria
- ☐ Migraine
- ☐ Jaundice
- ☐ Joint Problems
- ☐ Kidney Stones
- ☐ Knee Problems
- ☐ Mumps
- ☐ Nephritis
- ☐ Nervous Breakdown
- ☐ Nervousness
- ☐ Neuritis
- ☐ Paralysis
- ☐ Personality Changes
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rheumatism/Arthritis
- ☐ Rupture or Hernia
- ☐ Skin Disease
- ☐ Stroke
- ☐ Swollen Glands
- ☐ Thyroid Trouble
- ☐ Tremor Hands/Head
- ☐ Tuberculosis
- ☐ Scarlet Fever
- ☐ Sexual Problems
- ☐ Shortness of Breath
- ☐ Shoulder Trouble
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Tumors/Cysts
- ☐ Ulcers
- ☐ Unexplained Weight Gain
- ☐ Unexplained Weight Loss
- ☐ Unusual Weakness
- ☐ Varicose Veins
- ☐ Venereal Disease

If yes, please explain:

____

____

____

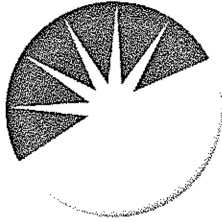
Are you allergic to any of the following?:

- ☐ Animal Dander/Feathers
- ☐ Foods
- ☐ House Dust
- ☐ Medications
- ☐ Serum
- ☐ Metal, Jewelry
- ☐ Sunlight
- ☐ Pollens
- ☐ Vaccines
- ☐ Other Allergies:______________________

If yes, please explain:

____

____



MS OCCUPATIONAL MEDICAL SERVICES

Your Partner in Employee Health

Have you taken any of the following in the past month?

- □ Antacids
- □ Antibiotics
- □ Anticoagulants
- □ Amphetamines
- □ Antidepressants
- □ Antihistamines
- □ Appetite Suppressants
- □ Aspirin
- □ Benzedrine
- □ Codeine
- □ Cortisone or Steroids
- □ Digitalis
- □ Hormones
- □ Diabetic Medications
- □ Insulin
- □ Blood Pressure Meds
- □ Laxatives
- □ Morphine
- □ Sleeping pills
- □ Sulfa Medications
- □ Thyroid Medication
- □ Tranquilizers
- □ Tylenol

Please list any medications that you take regularly:

____

____

Please answer the following questions:

Have you ever been rejected for insurance or by the Armed Forces because of your physical condition?
□ No □ Yes; if yes, please explain: ____________________

Are you fully or partially disabled in any way?
□ No □ Yes; if yes, please explain: ____________________

Have you ever worked with x-rays or radioactive materials?
□ No □ Yes; if yes, please explain: ____________________

Have you ever worked with asbestos or in a dusty trade such as : Mining, foundry work, sand blasting, smelting or chemicals?
□ No □ Yes; if yes, please explain: ____________________

Have you ever received treatment at a hospital?
□ No □ Yes; if yes, please explain: ____________________

Have you ever received a pension for physical disability?
□ No □ Yes; if yes, please explain: ____________________

Have you ever been a resident outside the United States?
□ No □ Yes; if yes, please explain: ____________________

Do you have any hobbies that require use of chemicals or other materials like solvents, solder, pesticides?
□ No □ Yes; if yes, please explain: ____________________

I have answered this Questionnaire completely and to the best of my ability.

____

Patient Print Name Sign Name Date

Canton: (410) 534-1203 ~ Greenbelt: (301) 220-1191
Arbutus: (443) 524-2737 ~ Belcamp: (410) 272-7756

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