

**Occupational History**

Working  Unemployed  Retired  Disabled   
Starting with your most recent job, list the type of work you have done  
Type of work Number of years  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Exposure in the past year:

Fumes & dust  Coal or asbestos   
Radiation  Lead or mercury   
Loud noises  Heavy lifting   
Other \_\_\_\_\_

**Other Problems**

Check if you have had any of these symptoms to an unusual or significant degree:

	No	Yes		No	Yes		No	Yes		No	Yes
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Dark (black) stools	<input type="checkbox"/>	<input type="checkbox"/>	Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Ear trouble	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty controlling urine	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Trouble seeing	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Increased urination at night	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Short of breath when you lie down	<input type="checkbox"/>	<input type="checkbox"/>	Any problems with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain with walking	<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>				Urinary infections	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol problem	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>				Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Tremor	<input type="checkbox"/>	<input type="checkbox"/>				Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>				Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<i>Past History of:</i>			Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Heart burn	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Nervous	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>

**INFECTION EXPOSURE:**

	Yes	No	Don't Know
1. Are you concerned you might have HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you concerned you might have hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel you are at risk for HIV based on blood transfusions before 1990, injection drug use, or sexual preference?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had intimate contact with someone known to have HIV or other STDs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What other practitioners do you see? \_\_\_\_\_

When did you last have a complete physical exam? \_\_\_\_\_

Dentist \_\_\_\_\_ Eye Doctor \_\_\_\_\_ Last eye exam \_\_\_\_\_

Have you had any recent blood work? Yes  No  When? \_\_\_\_\_ Where? \_\_\_\_\_

ECG? Yes  No  When? \_\_\_\_\_ Where? \_\_\_\_\_

Chest x-ray? Yes  No  When? \_\_\_\_\_ Where? \_\_\_\_\_

Are you up-to-date on your immunizations? Yes  No

Last tetanus booster \_\_\_\_\_

Do you have a living will? Yes  No  Do you have a durable power of attorney? Yes  No

**Women Only**

Menstrual history: Do you have any menstrual problems? \_\_\_\_\_

Date of last period \_\_\_\_\_ Number of pregnancies \_\_\_\_\_ Number of deliveries: vaginal \_\_\_\_\_ c-section \_\_\_\_\_

Frequency of periods \_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Number of terminations \_\_\_\_\_

Birth control method \_\_\_\_\_ Date of last mammogram \_\_\_\_\_ Self breast exam: Yes  No

SIGNATURE \_\_\_\_\_