PATIENT LABEL

AULTWORKS
Occupational Medicine

History Form — Page 1 of 5

NOTE: PLEASE PRINT AND BE AS COMPLETE AS POSSIBLE. THIS INFORMATION WILL BE HELD IN CONFIDENCE AND WILL HELP TO PLACE YOU IN THE PROPER JOB.

Company Name		Date
Name (Last, First, Middle)		Date of Birth
	Sex M F	Marital Status

LIST ALL YOUR PREVIOUS JOBS (Start with your Last Job)

JOB	EMPLOYER	DATES		REASON FOR LEAVING
		FROM	TO	

CHECK THE HIGHEST GRADE YOU COMPLETED IN SCHOOL

ELEMENTARY								HIGH				COLLEGE				Your Age on Leaving School
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	

	YES	NO	IF YES, EXPLAIN BRIEFLY
Have you ever worked in a dusty atmosphere?			
Have you ever worked with radioactive materials?			
Have you ever worked with poisonous materials?			
Have you ever worked in a noisy environment?			
Have you ever worked with Lead, Beryllium, Arsenic, Mercury, Benzene?			
Have you ever required a special job assignment because of the effects of illness or injury?			
Have you ever been rejected for a job or have you lost a job or quit because of your health?			
Have you ever received compensation or cash settlement for injuries, disease, or other medical problems from an employer or insurance company?			
Have you ever filed a claim or have any claim pending for injuries or illness related to your work? If so, claim number:_____			

Have you ever served in the United States Armed Forces?	☐ Yes ☐ No	IF YES, GIVE	Dates (From - To)		Branch	Theater	Type of Discharge
Were you ever rejected for military service?	☐ Yes ☐ No	If Yes, why?			Have you ever filed a claim or received payment for disability from the government?		☐ Yes ☐ No

HAS ANY IMMEDIATE RELATIVE (Mother, Father, Brother, Sister, Wife, Husband, Children) EVER HAD:

	YES	NO	IF YES, WHAT RELATIONS		YES	NO	IF YES, WHAT RELATIONS
Tuberculosis				Diabetes			
Cancer				Stroke			
Epilepsy or Seizures				Attempted Suicide			
Heart Trouble				Asthma, Hay Fever, or Other Allergy			

PATIENT LABEL

AULTWORKS
Occupational Medicine

History Form — Page 2 of 5

NAME: _____

HAVE YOU EVER HAD OR HAVE NOW:

	YES	NO		YES	NO		YES	NO
Arthritis or Rheumatism			Hearing Difficulties			Sugar or Protein in Urine		
Asthma			Goiter - Thyroid Disease			Recent Gain or Loss in Weight		
Bronchitis			Gall Bladder Trouble			Rheumatic or Scarlet Fever		
Cancer, Cyst, Tumor			Jaundice			Skin Trouble or Rash		
Diabetes or Sugar			Heart Trouble			Tuberculosis		
Epilepsy or Seizures			Neuritis, Nerve Trouble or Polio			Dislocation or Sprain of Joints		
Serioius Eye Trouble			Hernia or Rupture			Kidney Trouble		
Mental Disturbance			Foot Trouble			Back Trouble		
Allergy								

How much alcohol do you drink a week?				How much do you smoke a day?				What narcotics or mood drugs have you taken?	
None	Beers	Ozs. Wine	Ozs. Whiskey	None	Pipe	Cigars	Cigarettes		When?

	YES	NO	IF YES, STATE
Do you suffer from, or have you ever had a nervous condition or breakdown?			Circumstances
Have you ever had an operation? or been advised to have one?			What Operation and When Advised or Performed?
Have you ever had any broken bones or fractures?			What Bones? When?
Have you been treated by a doctor? or clinic in the last five years?			Clinic or Doctor and Reason?
Have you ever been a patient in a hospital?			Reason and Name of Hospital
Are you at present taking any medicine or drugs?			Condition and Medicine
Have you any medical condition that requires special consideration in job placement?			Condition
What is your present state of health? ☐ Good ☐ Fair ☐ Poor			Do you have any problems you would like to discuss with the doctor? ☐ Yes ☐ No

FEMALES ONLY:

No. of pregnancies	No. of miscarriages	No. of stillbirths	Any female disorders? ☐ Yes ☐ No	If so, explain	Date of last menstrual perod?

Are your periods regular? ☐ Yes ☐ No	Any bleeding between periods? ☐ Yes ☐ No	Painful periods requiring bed rest? ☐ Yes ☐ No	Regular Internal exam by the doctor? ☐ Yes ☐ No	Had any lumps in the breast? ☐ Yes ☐ No

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize investigation of all statements contained in this Medical History and do hereby release my prospective employer and AultWorks and my present and former employers, personal references named, or any other persons or organizations to whom my prospective employer and/or AultWorks may refer, from any liability for any damage as a result of providing or acting upon information regarding me. I understand that misrepresentation or omission of facts called for on this platform is cause for subsequent dismissal.

Date	Signature of Examinee

SUMMARY OF HISTORY AND ADDITIONAL HISTORY (To Be Supplied By Physician):

PATIENT LABEL

AULTWORKS
Occupational Medicine

History Form — Page 3 of 5

NAME: _____

Please complete this questionnaire as it relates to your past exposures, both prior to and as related to your present employment.

OCCUPATIONAL EXPOSURE INVENTORY:

	YES	NO
1. Please describe any health problems or injuries you have experienced connected with your present or past jobs.		
2. Have any of your co-workers also experienced health problems or injuries connected with the same jobs? If yes, please describe:		
3. Do you or have you ever smoked cigarettes, cigars, pipes, or used oral tobacco? If so, which and how many/much per day?		
4. Do you smoke while on the job, as a general rule?		
5. Do you have any allergies or allergic condition? If so, please describe:		
6. Have you ever worked with any substance which caused you to break out in a rash? If so, please describe your reaction and name the substance:		
7. Have you ever been off work for more than a day because of an illness or injury related to work? If so, please describe.		
8. Have you ever worked at a job which caused you trouble breathing, such as cough, shortness of breath, or wheezing? If so, please describe:		
9. Have you ever changed jobs or work assignments because of any health problems or injuries? If so, please describe:		
10. Do you frequently experience pain or discomfort in your lower back or have you been under a doctor's care for back problems? If so, please describe:		

11. Have you ever worked at a job or hobby in which you came into direct contact with any of the following substances by breathing, touching, or direct exposure? If so, please check the box beside the substance.

☐ Acids	☐ Beryllium	☐ Chromates	☐ Heat (severe)	☐ Nickel	☐ Radiation	☐ Trichloroethylene
☐ Alcohols (industrial)	☐ Cadmium	☐ Coal dust	☐ Isocyanates	☐ Noise (loud)	☐ Rock Dust	☐ Trinitrotoluene
☐ Alkalis	☐ Carbon tetrachloride	☐ Cold (severe)	☐ Ketones	☐ PBB's	☐ Silica Powder	☐ Vibration
☐ Ammonia	☐ Chlorinated napthalenes	☐ Dichlorobenzene	☐ Lead	☐ PCB's	☐ Solvents	☐ Vinyl Chloride
☐ Arsenic	☐ Chloroform	☐ Ethylene dibromide	☐ Manganese	☐ Perchloroethylene	☐ Styrene	☐ Welding fumes
☐ Asbestos	☐ Chloroprene	☐ Ethylene dichloride	☐ Mercury	☐ Pesticides	☐ Talc	☐ X-rays
☐ Benzene		☐ Fiberglass	☐ Methylene chloride	☐ Phenol	☐ Toluene	
		☐ Halothane		☐ Phosgene	☐ TDI or MDI	

If you have answered yes to any of the above, please describe your exposure on the back of this paper.

ENVIRONMENTAL INVENTORY:

	YES	NO
1. Have you ever changed your residence or home because of a health problem? If so, please describe:		
2. Do you live next door or very near an industrial plant? If so, please describe.		
3. Do you have a hobby or craft which you do at home? If so, please describe:		
4. Does your spouse or any other household member have contact with dusts or chemicals at work or during leisure activities? If so, please describe:		
5. Do you use pesticides around your home or garden? If so, please describe.		

6. Which of the following do you have in your home? (Please check all that apply.)

☐ Air Conditioner ☐ Air Purifier ☐ Humidifier ☐ Gas Stove ☐ Electric Stove ☐ Fireplace ☐ Central Heating

PATIENT LABEL

AULTWORKS
Occupational Medicine

History Form — Page 4 of 5

NAME: ______________________________

Please complete this questionnaire as it relates to your past exposures, both prior to and as related to your present employment.

TOXIC EXPOSURE HISTORY:

Complete the following history. Begin with your most recent job.

Project Title: ______________________ Location: ______________________

Work Activities: ______________________ Time Spent in Field: ______________________

SUSPECT HAZARDOUS MATERIALS ONSITE: ______________________

Including physical (noise, vibration, radiation), chemical (metals, acids, solvents) and biological (viruses, bacteria, etc.), materials.

If any of the above, please explain: ______________________

____

Protective Equipment: ______________________

Project Title: ______________________ Location: ______________________

Work Activities: ______________________ Time Spent in Field: ______________________

SUSPECT HAZARDOUS MATERIALS ONSITE: ______________________

Including physical (noise, vibration, radiation), chemical (metals, acids, solvents) and biological (viruses, bacteria, etc.), materials.

If any of the above, please explain: ______________________

____

Protective Equipment: ______________________

Project Title: ______________________ Location: ______________________

Work Activities: ______________________ Time Spent in Field: ______________________

SUSPECT HAZARDOUS MATERIALS ONSITE: ______________________

Including physical (noise, vibration, radiation), chemical (metals, acids, solvents) and biological (viruses, bacteria, etc.), materials.

If any of the above, please explain: ______________________

____

Protective Equipment: ______________________

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize investigation of all statements contained in this Medical History and do hereby release my prospective employer and AultWorks and my present and former employers, personal references named, or any other persons or organizations to whom my prospective employer and/or AultWorks may refer, from any liability for any damage as a result of providing or acting upon information regarding me. I understand that misrepresentation or omission of facts called for on this form is cause for subsequent dismissal.

Date	Signature of Examinee

SUMMARY OF OCCUPATIONAL HISTORY (To Be Supplied By Physician)

Date	Signature of Physician

PATIENT LABEL

AULTWORKS
Occupational Medicine

Physical Examination — Page 5 of 5

SEX M F	Date of Birth	Marital Status: S M W D Sep

Name _____
Last First Middle

Company _____ Job Title/Division _____

Height	Weight	Blood Pressure Sys/Dias	Rechecks
Temperature	Pulse	Resp Rate	

X-Ray ☐ Normal ☐ Abnormal

Urinalysis Alb_____Sugar_____Bld_____pH_____S.G._____

Audiometric ☐ Normal ☐ Abnormal

Electrocardiogram ☐ Normal ☐ Abnormal

Spirometry ☐ Normal ☐ Abnormal

Vision

				Normal	Abn
Far	☐ Uncorrected ☐ Corrected	R20	L20		
Near	☐ Uncorrected ☐ Corrected	R20	L20		
DEPTH				☐	☐
COLOR				☐	☐
PERIPHERAL				☐	☐

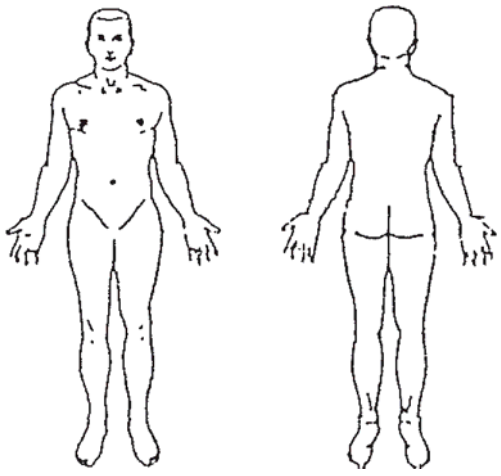
Allergies

Medications

Last Tetanus

	Normal	Abnormal	Not Done
1. APPEARANCE			
2. EYES			
3. EARS			
4. NOSE			
5. MOUTH			
6. TEETH & GUMS			
7. PHARNYX			
8. NECK & THYROID			
9. BREASTS			
10. THORAX			
11. LUNGS			
12. HEART			
13. ABDOMEN			
14. INGUINAL REGION			
15. ANUS & RECTUM			
16. GENITO-URINARY			
17. MUSCULO-SKELETAL			
18. EXTREMITIES			
19. SKIN			
20. LYMPH NODES			
21. NEUROLOGICAL			
22. MENTAL ATTITUDE			

DESCRIBE ABNORMALITIES



FOR PREPLACEMENT EXAMINATIONS ONLY:

☐ MEDICALLY ABLE TO PERFORM WITHOUT RESTRICTIONS

☐ MEDICALLY ABLE TO PERFORM WITH THE FOLLOWING RESTRICTIONS:

_____

_____

☐ NOT MEDICALLY ABLE TO PERFORM ESSENTIAL FUNCTIONS OF THE JOB

Comments: _____

_____

_____

_____

Physician Signature _____ Date _____