RUTGERS
New Jersey Medical School

Occupational Medicine Service
Rutgers, The State University of New Jersey
65 Bergen Street, Suite GA-167
Newark, NJ 07107

p. 973.972.2900
f. 973.972.2904

PATIENT INFORMATION

This information is confidential and will be used for office use only. Please PRINT legibly or complete electronically. (This Is A PDF Fillable Form)

Name: ……
Last First Middle

Mailing Address: ……
Street

……
City State Zip Code

Home Telephone Number: …….. **Mobile Telephone Number:** ……..

Date of Birth: …… **Age:** …… **Birthplace:** ……

E-Mail: ……..…… **Gender:** ☐ Male ☐ Female ☐ ……..

Race / Ethnicity: ☐ American Indian / Alaskan Native ☐ Black, not Hispanic ☐ Hispanic
☐ Asian / Pacific Islander ☐ White, not Hispanic ☐ Other ……..……..……

Maiden or Other Previous Names Used: ……..

Emergency Contact: …….. **Relationship:** ……

Emergency Telephone Number: ……

Have you ever been hospitalized or treated at the University Hospital of Newark? ☐ Yes, Year ……..... ☐ No

Have you ever been seen for any reason at the NJMS Occupational Medicine Service? ☐ Yes, Year …….. ☐ No

Current / Previous Employer: ……..

Position Applied For: ……..

School / Unit: ☐ CA ☐ NJMS ☐ SDM ☐ SGS ☐ SHP ☐ SN ☐ SPH ☐ UBHC ☐ Other: ……

Department: ..... **Work Location:** …….. **Work Telephone #:** ……..……..

Signature: …… **Today's Date:** ……

For Office Use Only – **Medical Record Number:** ……..……

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Employee Health History

Name (Please Print): ……

Last **First** **Middle**

NO	YES	General Health History – Please EXPLAIN all YES answers
		1. Visited a physician in the past year?
		2. Absent from work or school for a medical reason in the past year?
		3. Health worsened in the past year?
		4. Ever absent from work or school for an illness or injury related to work or due to a chemical or other hazard?
		5. Wear prescription eyeglasses or contact lenses?
		6. Any visual difficulties that are not correctable?
		7. Use dentures?
		8. Cold or sore throat more than twice a year?
		9. Recurrent ear infections or perforated eardrum?
		10. Difficulty hearing or an abnormal hearing test ever?
		11. Allergic to medicine(s)?
		12. Allergic to animal(s)?
		13. Allergic to latex?
		14. Hay fever, allergic to food or other substances in the environment?
		15. Special diet for medical reasons?
		16. Trouble smelling odors?
		17. Skin troubles?
		18. Skin rashes or diseases that prevent you from shaving (for men) or interfere with wearing a respirator?
		19. Any x-ray picture during the past year?
		20. An abnormal chest x-ray ever?
		21. Prescription medications over the past month?
		22. Other medicines, including for colds, diet and headaches, vitamins, and eye and nose drops over the past month?
		23. Hospital inpatient overnight?
		24. Currently pregnant (for women)? If NO, last menstrual period:
		25. Served in military or uniformed services?
		26. Any medical condition that requires you to restrict your activity?
		27. Ever advised to change jobs or work assignments because of any health problem or injury?
		28. Ever received compensation for any illness or injury resulting from work or military service?
NO	**YES**	**Communicable Diseases History – Please EXPLAIN all YES answers**
		29. Tuberculosis skin test (PPD) in the past 12 months?
		30. Positive or abnormal tuberculosis skin test ever?
		31. Tuberculosis disease?
		32. Told you need medicines for exposure to tuberculosis or for tuberculosis disease?
		33. Immunized with the BCG (Bacille Calmette-Guerin) tuberculosis vaccine?
		34. Lived or traveled outside the United States or Canada?
		35. Close contact with a family member or other person who had tuberculosis?
		36. Persistent cough, fever, night sweats, fatigue, chills, unexplained weight loss, shortness of breath or chest pain?
		37. Measles, mumps, or rubella (German measles)?
		38. Immunized with two (2) doses of measles, mumps, and rubella (MMR) vaccine?
		39. Chickenpox or varicella (disease)?
		40. Immunized with two (2) doses of chickenpox or varicella vaccine?
		41. Immunized for tetanus (tetanus shot) in the past 10 years?
		42. Immunized with the Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine within the past 10 years?
		43. Received a blood transfusion ever?
		44. Exposed in a previous job to blood or body fluids that may have contained bloodborne pathogens, including hepatitis B virus, hepatitis C virus, or human immunodeficiency virus?
		45. Hepatitis or jaundice?
		46. Immunized with three (3) doses of hepatitis B vaccine?
		47. Positive Hepatitis antibody (demonstrating immunity)?
		48. Immunized with influenza vaccine this season?

NO	YES	Noncommunicable Diseases History – Please EXPLAIN all YES answers
		49. Do you take medication for the following: breathing problems, blood pressure, seizures, or heart trouble?
		50. Chest pain when you exert yourself, for example, when climbing stairs, walking, or running?
		51. Coronary artery disease or other heart disease?
		52. Had a heart attack, coronary bypass surgery or any treatment for coronary artery disease?
		53. Palpitations, rheumatic fever or heart murmur?
		54. Blood pressure is greater than 150/90 with or without medication?
		55. Quickly become short of breath when climbing stairs or walking
		56. Asthma? If yes, latest episode:
		57. Chronic cough, other respiratory problem or chronic lung disease, for example, emphysema or bronchitis?
		58. An abnormal lung function test ever?
		59. Frequent or persistent stomach or other intestinal trouble?
		60. Liver disease?
		61. Hernia?
		62. Back pain ever? If yes, latest episode:
		63. Broken bone or dislocation?
		64. Painful, swollen, or stiff shoulder, arm, wrist, finger, leg, knee, or foot?
		65. Headaches that incapacitate you?
		66. Seizure disorder or epilepsy, paralysis or history of fainting or being unconscious?
		67. Claustrophobia?
		68. Difficulty reading or learning disability?
		69. Kidney or bladder trouble or blood in your urine?
		70. Diabetes mellitus?
		71. Weight change in the past year?
		72. Treated for a cyst, growth, tumor, or cancer?
		73. Immune suppression or deficiency?
		74 . Amputation?
		75. Any surgical operation?
NO	**YES**	**Other Exposures History – Please DISCUSS all YES answers**
		76. Smoke cigarettes currently?
		77. Smoked cigarettes ever?
		78. Used other tobacco products ever? If so, list type of product here:
		79. Drink alcohol, including beer, wine, or other liquor?
		80. If you drink alcohol, ever attempted to cut down on your drinking, annoyed by other people criticizing your drinking, felt guilty about drinking or taken a morning eye-opener?
		81. Injured in a road traffic crash, fight, or assault?
		82. Worked with anesthetic gases, anticancer agents, ethylene oxide, formaldehyde, or glutaraldehyde?
		83. Worked with hazardous waste, benzene, carbon tetrachloride, irritant dusts, isocyanates, paints, pesticides, petroleum products, phenol, silica, solvents, toluene or welding fumes?
		84. Worked with chromium, lead, mercury, or other metals?
		85. Worked with radioactive materials or radiation-producing machines?
		86. Exposed to loud noise for over one month?
		87. Worked in a hospital or other health care facility?
		88. Worked with asbestos or in building construction, mining, pipefitting, plumbing, chemical plant, foundry, refinery, or shipyard?
		89. Exposed to chemical or other hazards not noted above?
		90. Worked in other environments with materials that concern you?
		91. Advised to wear personal protective equipment on a job?
		92. Difficulty wearing latex gloves or other personal protective equipment?
		93. Worn a respirator ever?
		94. Difficulty using a respirator or medically restricted from using a respirator?
		95. Any symptoms from exposure to chemical or other hazards?
		96. Any hobby activities that expose you to dusts, chemicals or fumes?
		97. Any other medical problems not noted above or other circumstances that should be reported to fairly complete these questions and determine medical factors for fitness for duty and job placement?
		98. Would you like to talk to a health professional about any of your answers above?
		99. Please specify: Left-handed or Right-handed?

I certify that the above is accurate and true to the best of my knowledge.

……

Signature **Date**