

Industrial Medical History Form

If you are here for a physical exam complete this form in full.

Today's Date: _____

Patient Name: _____

Date of Birth: _____

1. Are you currently under medical treatment?.....

Yes No

Please describe: _____

2. Have you ever had any serious illnesses or operations?.....

Yes No

Please describe: _____

3. Are you currently taking any medications?.....

Yes No Please describe: _____

4. Do you smoke?.....

Yes No

5. Do you use alcohol?.....

Yes No

6. Have you had any allergic reactions to the following:

Local Anesthetics (such as Novocaine).....

Yes No

Sedatives.....

Yes No

Penicillin or other Antibiotics.....

Yes No

Iodine.....

Yes No

Sulfa Drugs.....

Yes No

Aspirin.....

Yes No

Barbiturates (sleeping pills).....

Yes No

Other.....

Yes No

Please describe: _____

7. Women Only:

Do you have regular periods?.....

Yes No

Are you taking birth control pills?.....

Yes No

Are you (or could you be) pregnant?.....

Yes No

8. Have you ever had: Yes No

Anemia (low blood count).....

Anorexia (no appetite).....

Arthritis.....

Asthma.....

Back problems.....

Bleeding tendency.....

Blood disease.....

Cancer.....

Chemical dependency.....

Chemotherapy.....

Chicken pox.....

Chronic fatigue syndrome.....

Circulatory problems.....

Congenital heart lesions.....

Cough – persistent or bloody.....

Diabetes.....

Emphysema.....

Epilepsy.....

Glaucoma.....

Heart murmur.....

Heart attack/disease.....

Hepatitis-Type____.....

Hernia.....

Herpes.....

High blood pressure.....

High cholesterol.....

HIV/AIDS.....

Jaundice.....

Kidney disease.....

Latex sensitivity.....

Liver disease.....

Low blood pressure.....

Measles.....

Migraine headaches.....

Mitral valve prolapse.....

Mumps.....

Multiple sclerosis.....

Pacemaker.....

Pneumonia.....

- Polio.....
- Prostate problem.....
- Psychiatric care.....
- Respiratory disease.....
- Rheumatic fever.....
- Scarlet fever.....
- Shortness of breath.....
- Sinus trouble.....
- Skin rash.....
- Stroke.....
- Thyroid problems.....
- Tonsillitis.....
- Tuberculosis.....
- Tumor.....
- Ulcer.....
- Venereal disease.....
- Other (specify).....
