OCCUPATIONAL MEDICINE
5070 International Blvd, Ste 131
North Charleston, SC 29418
Ph: (843) 402-5053

Name: ____________________

DOB: ____________________

Company: ____________________

A. Occupational History

1. Have you ever been exposed to hazardous substances in your job? ☐ Yes ☐ No

2. Have you ever been told by a healthcare professional that you are allergic to any latex (natural rubber) products? (If so, please provide documentation.) ☐ Yes ☐ No

3. Have you ever had contact with any substance or items that caused a reaction (i.e., latex gloves, medical devices, personal items – balloons, condoms, band-aids, adhesive tapes, clothing with elastic or stretch fabrics)? ☐ Yes ☐ No

4. Do you have allergies to any foods, including avocados and bananas? ☐ Yes ☐ No

5. Have you ever had an adverse or allergic reaction or anaphylaxis during a medical/ surgical/dental procedure (rashes, eye tearing, lethargy, sneezing, runny nose, numbness, tingling mouth or facial redness/swelling)? ☐ Yes ☐ No

6. Have you ever worked with sheet metal or welding/soldering or had an accident where metal fragments did or may have become embedded in your eyes or any other area of your body? ☐ Yes ☐ No

7. Have you ever been injured at work? ☐ Yes ☐ No

Please explain any items answered yes:

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Signature: ______________________________ Date: ____________________

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Name: ______________________________
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List the jobs you've had since you first started working. Include the years worked at each job.

Also, include any military experience. Use the back of this form if additional space is needed.

Date	Employer name Product or service provided	Job title and specific duties	Major exposures (such as dusts, chemicals, noise, repetitive motion, stress	Protective equipment (such as gloves, earplugs, respirators)
Example: 2014-2015	Acme Industries: shoe polish manufacturer	Inspector	Shoe polish, solvents, trichloroethylene	Respirator, earplugs

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B. Communicable Disease and Immunization History

Illness/Virus	Immunization	Have you had the condition/virus?	Illness/Virus	Immunization	Have you had the condition/virus?
Chickenpox	□ Yes □ No	□ Yes □ No	Meningitis	□ Yes □ No	□ Yes □ No
Shingles	□ Yes □ No	□ Yes □ No	Whooping Cough	□ Yes □ No	□ Yes □ No
Hepatitis A	□ Yes □ No	□ Yes □ No	Rubella	□ Yes □ No	□ Yes □ No
Hepatitis B	□ Yes □ No	□ Yes □ No	Polio	□ Yes □ No	□ Yes □ No
Hepatitis C		□ Yes □ No	Diphtheria	□ Yes □ No	□ Yes □ No
Measles	□ Yes □ No	□ Yes □ No	Tetanus	□ Yes □ No	□ Yes □ No
Mumps	□ Yes □ No	□ Yes □ No	Covid Vaccine	□ Yes □ No	

Additional information:

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C. Medication History. Please list the information about the medications you are taking NOW:

Name of Medication	Strength	How often taken	Reason you are taking it	How long have you been taking it?

Additional information:

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Signature: ____________________ Date: ____________________

Teammate Health

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D. Medical History/Symptoms.

Have you EVER or do you NOW have any of the following (please check all that apply):

Mouth, Ear, Eye, Nose

Glasses or contact lenses	□ Yes □ No
Recent change in your vision	□ Yes □ No
Color blindness	□ Yes □ No
Eye disease	□ Yes □ No
Hearing loss	□ Yes □ No
Ringing in ears	□ Yes □ No
Dizziness	□ Yes □ No
Hayfever/Seasonal allergies	□ Yes □ No
Nose bleeds	□ Yes □ No
Recurrent sinus infections	□ Yes □ No
Difficulty smelling odors	□ Yes □ No
Chew tobacco now or in the past	□ Yes □ No

Lungs

Asthma/Wheezing	□ Yes □ No
Persistent cough	□ Yes □ No
Emphysema/Bronchitis	□ Yes □ No
Pneumonia	□ Yes □ No
Shortness of breath	□ Yes □ No
Obstructive Sleep Apnea	□ Yes □ No
Tuberculosis	□ Yes □ No
Positive skin test for TB	□ Yes □ No
Receiving BCG or TB therapy	□ Yes □ No
Smoking, now or in the past	□ Yes □ No

Cardiovascular

Chest pain	□ Yes □ No
Shortness of breath	□ Yes □ No
Heart attack/myocardial infarction	□ Yes □ No
Palpitations/irregular heart beat	□ Yes □ No
Fainting	□ Yes □ No
Heart murmur	□ Yes □ No
High blood pressure	□ Yes □ No

Gastrointestinal

Abdominal pain (longstanding)	□ Yes □ No
Indigestion or heartburn	□ Yes □ No
Diarrhea (recent or longstanding)	□ Yes □ No
Irritable bowel syndrome	□ Yes □ No
Hepatitis and/or Jaundice	□ Yes □ No
Gastric bypass surgery	□ Yes □ No
Ostomy	□ Yes □ No

Endocrine (Glands)/Metabolic/Renal/GU

Diabetes	□ Yes □ No
"High" or "low" blood sugar	□ Yes □ No
Thyroid disease	□ Yes □ No
Gout	□ Yes □ No
Osteoporosis	□ Yes □ No
Chronic Renal Insufficiency	□ Yes □ No
Self-catherization	□ Yes □ No

Neurologic/Behavioral Health

Migraine headache	□ Yes □ No
Other frequent headache	□ Yes □ No
Seizure	□ Yes □ No
Tremor	□ Yes □ No
Narcolepsy	□ Yes □ No
Shift work disorder	□ Yes □ No
Insomnia	□ Yes □ No
Stroke/TIA	□ Yes □ No
Multiple sclerosis	□ Yes □ No
Carpal Tunnel Syndrome	□ Yes □ No
Other Neuropathy	□ Yes □ No
Fainting	□ Yes □ No
Depression	□ Yes □ No
Anxiety	□ Yes □ No
Other psychological condition	□ Yes □ No

Skin

Eczema, Psoriasis, or Hives	□ Yes □ No
Excessive dry skin	□ Yes □ No
Soap allergy	□ Yes □ No
Latex allergy	□ Yes □ No
Other skin allergy/sensitivity	□ Yes □ No
Skin cancer	□ Yes □No

Other information about items answered "Yes"

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Musculoskeletal/Rheumatologic Conditions

Neck or Back

Neck or back injuries	□ Yes □No
for neck or back	□ Yes □No
Sciatica (pain that goes down leg)	□ Yes □No
Problems bending, twisting, turning	□ Yes □No
Recurrent neck or back pain or spasms	□ Yes □No
Herniated, "slipped", or "ruptured" disc	□ Yes □No
Neck or back surgery	□ Yes □No
Physical therapy or chiropractic treatment	
Stenosis, scoliosis or spondylolithesis	□ Yes □No
Time lost or limited duty from work due to neck or back injury or other problems	□ Yes □No

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Neck or Back

Permanent work restrictions because of of neck or back problems	☐ Yes ☐No
Osteoporosis, osteopenia, fracture	☐ Yes ☐No
Wear a brace or wrap on back, either occasionally or constantly	☐ Yes ☐No

Shoulder

Shoulder injuries or problems	☐ Yes ☐No
Shoulder surgeries	☐ Yes ☐No
Physical therapy or chiropractic therapy for shoulder problems	☐ Yes ☐No
Problems with lifting, pulling or pushing	☐ Yes ☐No

Knees

Knee pain or discomfort of any kind	☐ Yes ☐No
Knee surgeries	☐ Yes ☐No
Problems or pain with squat, kneel, walking, climbing stairs/ladders	☐ Yes ☐No
Physical therapy for knee problems	☐ Yes ☐No
Wear a brace or wrap on knee either occasionally or constantly	☐ Yes ☐No

Ankles, Foot

Ankle/foot pain or discomfort of any kind	☐ Yes ☐No
Sprain, fracture of ankle	☐ Yes ☐No
Surgeries to ankles or feet	☐ Yes ☐No
Physical therapy for ankles or feet	☐ Yes ☐No
Arthritis, bone spur, plantar fasciitis, flat feet, bunions	☐ Yes ☐No
Wear a brace or wrap on ankle, either occasionally or constantly	☐ Yes ☐No
Problems with continuous stand/walk	☐ Yes ☐No

Elbow, Wrist, Hand, Finger

Elbow, wrist, hand, finger pain discomfort of any kind	☐ Yes ☐No
Surgeries to elbow, wrist, hand, finger	☐ Yes ☐No
Numbness, tingling or clumsiness in hands or fingers	☐ Yes ☐No
Carpal tunnel syndrome	☐ Yes ☐No
Tendonitis or tennis elbow	☐ Yes ☐No
Problems with lifting, pushing, power grasp, pinch, or fine manipulation or movement	☐ Yes ☐No
Wear a brace or wrap on elbow or wrist Either occasionally or constantly	☐ Yes ☐No

Other Medical or Surgical History

Hernia or hernia repair surgery	☐ Yes ☐No
Appendectomy	☐ Yes ☐No
Bariatric surgery	☐ Yes ☐No
Other abdominal surgery	☐ Yes ☐No

WOMEN ONLY

Gynecologic concerns under care of physician?	☐ Yes ☐No
Are you pregnant?	☐ Yes ☐No

Other conditions or information about items answered "Yes"

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Past Surgical History and Date: ____________________

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TB Screening

What was the result of your last PPD skin test?	☐Neg	☐Pos
Have you ever been exposed to anyone with TB?	☐ Yes	☐ No
Do you have leukemia, lymphoma or another cancer?	☐Yes	☐No
Have you experienced an unexplained weight loss?	☐Yes	☐No
Have you had a recent fever?	☐Yes	☐No
Do you have night sweats?	☐Yes	☐No
Do you have a persistent cough (dry,wet or bloody)?	☐Yes	☐No
Are you immunosuppressed?	☐Yes	☐No

Signature: ______________________________ Date: ________________