COMPREHENSIVE OCCUPATIONAL AND ENVIRONMENTAL EXPOSURE QUESTIONNAIRE

You have been scheduled for an appointment at Resources for Environmental and Occupational Health (REOH). This questionnaire will help streamline your evaluation and allow you to think about the questions you will be asked by the physician about your health. **PLEASE COMPLETE THIS QUESTIONNAIRE AND BRING IT TO REOH WHEN YOU COME FOR YOUR APPOINTMENT**. If you need additional space for any question, please use the back of this form.

Name:	Date of Birth:
Current Employer:	Address of employer:

CHIEF COMPLAINT

1. What is the health problem for which we are seeing you?

2. What symptoms do you attribute to this health problem?

3. When did you first notice the health problem for which we are seeing you?

4. What do you believe caused the health problem? If this is related to a chemical exposure, please describe the substance and product name (if available, a copy of the product label or Material Safety Data Sheet (MSDS) would be helpful).

5. Have you missed more than a day of work because of this health problem? If yes, please describe when you missed work or the date of your last day of work.

EMPLOYMENT HISTORY

List all jobs you have worked in the past 10 years, including short term, seasonal, and/or part-time employment. Start with your most recent job and go back in chronological order:

DATES OF EMPLOYMENT	EMPLOYER'S NAME	LOCATION (CITY AND STATE)	JOB TITLE	AVERAGE HOURS WORKED/WEEK

Have you ever served in the military? Yes No

If yes, please list the branch of service and years when you served: _____

Have you ever had a previous workers' compensation claim for an injury or illness related to your work? Yes No

If yes, please describe the injury/illness, when it occurred, and the cause: _____

PAST MEDICAL HISTORY

Do you have any other medical conditions for which you currently see a physician or take prescription medications? Yes No

If yes, please describe the condition and when it was first diagnosed or treated (examples of possible conditions may include high blood pressure, diabetes, reflux, thyroid disease, gout, arthritis, asthma, sleep apnea, allergies, hay fever, depression, or others):

Health condition	Year first diagnosed

Have you had any previous surgeries? Yes No

If yes, please list the surgery and the year when you had it:

Surgery	Year of surgery

Have you ever been hospitalized for more than one day for an injury or illness? Yes No

If yes, please describe the health condition and year when you were hospitalized:

Reason for hospitalization	Year of hospitalization

Do you have a current primary care provider? Yes No

If yes, who is your primary care provider: _____

Do you currently see any other health care providers such as a chiropractor, massage therapist, naturopath, acupuncturist, or others? Yes No

If yes, what other health care providers do you currently see? _____

FAMILY HISTORY

Are there any health conditions that seem to run in your immediate family (i.e., parents, siblings, or children)? Yes No

If yes, please list the condition and the affected family members. Examples of possible health conditions may include cancer, diabetes, heart disease, thyroid disease, asthma, allergies, rheumatoid arthritis, or others:

Health condition	Parents	Sibling	Children

SOCIAL HISTORY

Are you currently married? Yes No

Do you have any children? If yes, please list their ages: _____ Yes No

What is the highest level of education you reached (grade): _____

Do you smoke cigarettes currently? Yes No

If yes, how many cigarettes or packs do you smoke per day? _____

How many years have you smoked cigarettes? _____

If you do not currently smoke cigarettes, have you smoked in the past? Yes No

If yes, what was the average number of cigarettes or packs you smoked per day? _____

How many years did you smoke? _____

Do you other tobacco products such as cigars, pipes, or chewing tobacco? Yes No

If yes, please describe the product you use, how often you use it, and the length of time you have been using it:

Tobacco product	Frequency of use	Number of years used

Do you drink alcohol? Yes No

If yes, do you drink alcohol every day? Yes No

If yes, what is the average number of alcohol drinks you have per week (one drink equals one beer, one glass of wine, or one shot of liquor)? _____

Do you currently use marijuana (medical or otherwise)? Yes No

If yes, what is the average number of times per week that you use marijuana? _____

Do you drink caffeinated beverages such as coffee, tea, or sodas? Yes No

If yes, what is the average number of caffeinated drinks you have per day? _____

What types of hobbies or activities do you like to do when not working? _____

REVIEW OF SYSTEMS

Circle all symptoms you have experienced in the past six months:

Orthopedic	*Ear, Nose, Throat*	*Cardiovascular*
Low back pain	Hearing loss	Chest pain
Neck pain	Ringing in ears	Chest pain with exertion
Pain in the arms	Nosebleeds	Ankle swelling
Pain in the legs	Sinus infections	Rapid heartbeat
Joint pain	Persistent sore throat	Skipped beats
Swollen joints	Hoarseness	Increased cholesterol
Arm/leg weakness	Loss of voice	Increased triglycerides
Arm/leg numbness		Sleep in recliner
Neurologic	*Respiratory*	*Gastrointestinal*
Headaches	Shortness of breath	Nausea
Fainting	Cough	Vomiting
Dizziness	Coughing up blood	Vomiting blood
Loss of balance	Wheezing	Diarrhea
Blurred vision	Increased sputum	Heartburn or reflux
Speech difficulty	Pneumonia	Decreased appetite
Seizures	Hay fever	Difficulty swallowing
Memory problems		Pain with swallowing
Difficulty concentrating	*Urinary*	Weight loss more than 10 pounds
Depression	Blood in urine	
Anxiety	Kidney stones	*Skin*
	Pain with urination	Skin rash
	Abnormal urine color	Skin infections

MEDICATIONS

List all prescriptions and non-prescription medications you currently take:

MEDICATION	DOSE	TIMES PER DAY	REASON YOU TAKE IT

Do you use any alternative medicine substances such as herbs/botanicals or naturopathic substances? Yes No

If yes, list the substance, dose, frequency, and reason you take it:

SUBSTANCE	DOSE	TIMES PER DAY	REASON YOU TAKE IT

ALLERGIES

Do you have any medication allergies? Yes No

If yes, list the medications you are allergic to and the reaction they cause: _____

Do you have any food allergies? Yes No

If yes, list the foods you are allergic to and the reaction they cause: _____

Do you have any other allergies not discussed above such as metals, pets, pollens, grasses, weeds, etc.? Yes No

If yes, list the other substances you are allergic to and the reaction they cause: _____

OTHER

Is there anything else you would like us to know about your history not covered by this questionnaire?

Signature Date