2800 Tamarack Ave
Suite 001
South Windsor, CT 06074
860-647-4796

Department of Occupational Health

OCCUPATIONAL HEALTH WORK, ENVIRONMENT AND HEALTH QUESTIONNAIRE

Last Name:	**First Name:**
Date of Birth:	**Social Security Number:**
Street Address:	**City:**
State:	**Zip Code:**
Home Phone:	**Cell Phone:**
Email:	**Ethnicity**: ☐ Hispanic ☐ non-Hispanic ☐ Decline to specify
Company Name: **Position:** **Work Phone:**	**Race:** ☐ Caucasian/ White ☐ African American ☐ Asian ☐ Native American ☐ Hispanic ☐ Unknown ☐ Decline

OCCUPATIONAL HISTORY

List every place where you have been employed for **more than six (6) months** back to your first job, starting with your current or most recent job.

Start Mo/ Yr	End Mo/ Yr	Employer, City State	Type of Business	Job Title	Job Duties	Exposures

Have you ever worn a respirator at work? Yes _____ No _____

Were you able to perform your job with a respirator on? Yes _____ No _____

Do you wear contact lenses? Yes _____ No _____

Do you wear hearing aids? Yes _____ No _____

Do you wear glasses? Yes _____ No _____

Hobbies:_____

_____

_____

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SMOKING AND ALCOHOL USE

Have you ever smoked cigarettes regularly? Yes _____ No _____

If yes, do you still smoke? Yes _____ No _____

When did you quit smoking? (Date) _____

How many years have you smoked, or if you no longer smoke, how many years did you smoke? _____ yrs.

On the average, how many packs per day do you smoke, or if you no longer smoke, how many did you smoke? _____ packs per day.

Have you ever smoked a pipe or cigars regularly? Yes _____ No _____

Have you ever been a regular consumer of beer or other alcohol? Yes _____ No _____

FAMILY PHYSICIAN

Name: _____

Address: _____

Telephone Number _____ Date last seen by a physician: _____

Are any other physicians currently treating you? Yes ____ No ____

If yes, please write their name, address and telephone number:

_____

_____

_____

MEDICAL HISTORY

Current Medications: _____

_____

Allergies to medications and other substances: _____

_____

Have you ever been in the hospital? Yes _____ No _____

If yes, when, where, and why? _____

_____

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MEDICAL HISTORY CONTINUED

Do you have or have you ever had any of the following:

	YES	NO	Date of Onset	If yes, Please Detail
Have you received COVID Vaccine				
Arthritis, Rheumatic Fever				
Liver Disease, including Hepatitis				
Skin Condition				
Infertility, Child with Birth defect				
Tuberculosis				
Ulcers, Other Stomach or Bowel Disease				
Gallbladder Disease				
Disorder of Bones or Muscles				
Fractures				
Thyroid Problems				
Diabetes				
Kidney Disease				
Problems with Peripheral Nervous System (Weakness/ Seizures)				
Rupture of Eardrum, Hearing Loss				
Cancer or Tumor (type)				
Epilepsy (Seizures)				
Back Injury, Pain or Trouble				
Lung Conditions (Bronchitis, Emphysema, Pneumonia, Asthma, Blood clot in lungs)				
Injuries to other Body Parts				
Heart Disease, Including Hypertension				
Other Condition				
Date of Last Eye Exam				

Signature of Patient: _____ Date: _____

Signature of Provider: _____ Date: _____

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PHYSICAL EXAM FORM

NAME:_____ **DOB:**_____ **M / F**

JOB TITLE:_____

Vital Signs

Height Weight BP(repeat if needed) Rest/Exercise Pulse Tem Resp Rate

Urinalysis

Color	Leukocytes	Nitrite	Protein	pH	Blood	Spec grv	Ketone	Glucose

Vision: indicate best vision with or without correction and status of color vision.

Near ☐ with / ☐ without		Far ☐ with / ☐ Uncorrected		Peripheral Vision	Color
Right	20/	Right	20/	Right °	Ishihara☐ Pass/☐ Fail
Left	20/	Left	20/	Left °	Color sticks☐Pass/☐Fail
Both	20/	Both	20/		Other

Exam Findings (Normal, Abnormal, Not Examined)

	Norm	Abn	N/E	Findings
General Appearance				
Skin				
Eyes				
Ears Forced Whisper				Forced whisper R feet, L feet
Nose				
Throat				
Neck				
Chest				
Lungs				
Heart				
Abdomen				
Hernias				
Genitourinary				
Cervical Spine				
Thoracic Spine				
Lumbar Spine				
Shoulders				
Elbows/Forearms				
Wrists/Hands				
Hips				
Knees				
Ankle/Foot				
Neuro/Reflexes				

Pending (circle) Bloodwork PPD CXR Spirometry Med Records _____

Nurse/MA:_____ Date:_____

Physician/PA:_____ Date:_____