Name	Patient #	Date
Address	**Date of Birth**	**Current Occupation**
	□ Female □ Male	
Phone (home)	**Phone (work)**	**Phone (cell)**
Other medical providers whom you see (specialty, name, address and phone number)		

Chief complaint: What brings you to the clinic today?

Allergies
Current Medications

Family History	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorders						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						
Other (specify)						

Hospitalizations or Surgeries			
Reason	**Date**	**Reason**	**Date**

Habits and Sleep: Please check all that apply. Not all choices are relevant to all individuals.

Smoking cigarettes/cigars/pipes □ Never □ Exercise Routine (explain) □ Fat Intake: _____ grams of fat per day
Packs per day _____ _____ □ Difficulty falling asleep
Years smoked _____ □ Coffee: _____ cups per day □ Difficulty staying asleep
Date stopped _____ □ Other Caffeine: _____ cups per day □ Snoring
Do you chew tobacco? □ Yes □ No □ Alcohol: _____ glasses per day □ Early morning awakening (unintentional)
Do you use e-Cigarettes? □ Yes □ No □ Salt Intake: _____mg of salt per day □ Do you have a living will? □ Yes □ No

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The following 3 pages asks about your medical history and symptoms, types of jobs and hobbies or craft activities, and exposures and chemicals you may have encountered. Please provide information as best as you can remember and if you feel comfortable doing so. Not all choices apply to everyone. You are being asked these questions to help your provider better understand your symptoms or complaints, why they may be occurring, and how to best help you.

Medical History and Review of Symptoms: Please check all that apply to you. Not all choices apply to all individuals. Have you experienced any of the following? Check all that apply.

□ Weight loss	□ Chronic obstructive pulmonary disease (COPD)	□ Ulcer	□ Rheumatoid arthritis
□ Weight gain		□ Gastrointestinal disorder	□ Skin rash
□ Fatigue	□ Bronchitis	□ Lactose intolerance	□ Eczema
□ Fevers	□ Pneumonia	□ Gallbladder disease	□ Dermatitis
□ Headache/Migraine	□ Acute viral illness	□ Hepatitis	□ Psoriasis
□ Hearing problems	□ Immune deficiency states	□ Blood in stool or urine	□ Poor wound healing
□ Vision problems/Wear contact lenses or glasses	□ Immunosuppressive therapy	□ Urinary tract infections	□ Diabetes
	□ HIV/AIDS	□ Kidney stones	□ Thyroid disease
□ Glaucoma □ Heart palpitations/skipped beats □ Kidney disease □ Overweight/obesity □ Dizziness/Vertigo □ Fainting □ Bladder/Bowel control □ Vitamin deficiency problems (specify)			
□ Epilepsy/convulsions	□ Chest pain or tightness	□ Sexual dysfunction	
□ History of head /brain injury	□ Heart murmur	□ Irregular periods	
□ Depression/anxiety	□ Rheumatic fever	□ Prostate/testicular disease	□ In-born errors of metabolism (specify)
□ Seasonal allergies	□ Hypertension (high blood pressure)	□ Sexually transmitted diseases	
□ Sinus problems			
□ Tiredness/daytime sleepiness □ Blood vessel disease □ Back pain your vaccinations up to □ Unable to tolerate heat/cold	□ Cardiovascular disease	□ Have you had a flu vaccination this year? Are	□ Shortness of breath with/without exertion □ Heart attack □ Neck pain date? □ Yes □ No □
	□ Stroke	□ Shoulder pain	
Wheezing □ Peripheral vascular disease		□ Elbow pain	If no, please explain:
□ Cough	□ Anemia	□ Arm/wrist/hand pain	
□ Allergies	□ Easy bruising/bleeding or bleeding disorder	□ Hip pain	□ Other symptoms, illness or injury (specify)
□ Hay fever		□ Knee pain	
□ Atopy	□ Indigestion/heartburn	□ Leg/ankle/foot pain	
□ Allergic rhinitis	□ Abdominal or groin pain	□ A history of broken bones	
□ Asthma	□ Diarrhea		
□ Emphysema	□ Constipation	□ Osteoarthritis	

Please check occupation groups in the first column and circle specific types of work in the second column that you may have done. Not all work types apply to everyone. The list is not exhaustive. Please complete only if you wish to do so.

□ Agriculture, Forestry & Fishing (except Wildland Firefighting)	Agriculture, farming, fishing, forestry, lumber industry
□ Construction	Construction, demolition, HVAC, masonry, painting/spray painting, plumbing/pipefitting, road work/maintenance, sandblasting, welding
□ Healthcare & Social Assistance	Healthcare, dental work, laboratory work
□ Manufacturing	Automobile/bike/aircraft/ship manufacturing and repair, biotechnology, boiler operations/cleaning, carpentry, ceramics, chemical industry, electrical/electronics, foundry work, jewelry making, machinery/grinding, metalwork, paper, plastics manufacturing/molding, printing/lithography, textile industry/dye manufacturing, woodwork
□ Mining (except Oil and Gas Extraction)	Coal, metals, other
□ Oil and Gas Extraction	Oil, gas, petrochemical
□ Public Safety	EMS, paramedic/police work, firefighting(including Wildland Firefighting), other first responder
□ Services (except Public Safety)	Baking/food handling, computer services, dry cleaning/laundry, information technology, personal care/grooming services, real estate
□ Transportation, Warehousing & Utilities	Truck/taxi driving, logistics, warehousing
□ Wholesale and Retail Trade	Sales, distribution
Other:	

Have you experienced any health problems or injuries in present or past jobs? □ Yes □ No □ Maybe □ Don't Know

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If yes, maybe, or don't know, then please describe your situation. ___________________________________ ______________________
____
Do these problems change when you are away from work? ☐ Yes ☐ No If yes, how? ☐ Worse ☐ Same ☐ Better

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Do you have any of the following?	Yes	No	Don't Know	If yes, please describe:
Co-workers with similar health problems or injuries	☐	☐	☐	
Working with any substances causing a rash	☐	☐	☐	
Off work more than a day because of illness or injury	☐	☐	☐	
Job causing you trouble breathing, such as cough, shortness of breath, wheezing	☐	☐	☐	
Changing jobs or work assignments because of health problems or injuries	☐	☐	☐	
Smoking cigarettes/cigars/pipes/chewing tobacco on the job	☐	☐	☐	
Changing your residence or home because of a health problem	☐	☐	☐	
Living near an industrial plant/in a high pollen area/wooded or forest area	☐	☐	☐	
A hobby or craft at home	☐	☐	☐	
A spouse or other household member in contact with dusts, chemicals, or biological agents at work or home	☐	☐	☐	
An air conditioner, air purifier, humidifier, gas stove, wood burning stove, gas fireplace, wood burning fireplace, indoor dampness, and/or mold in your home (circle all that apply)	☐	☐	☐	

Occupational Profile: ***Optional***. Please list your current job and the one before that, including short-term, seasonal, and part-time employment (list present job first). Use additional paper if needed, or you may bring a resume. Alternatively, you may provide this information when speaking directly with your health care provider.

Workplace (Employer's name and used? work for a optional; please start with your current job	Dates Worked: many Industry describ week did	How e your hazards in per solvents, etc.)	Type of equipment	List your occupation and ever off address or city – From problem or and work backwards)	Know health To hours (dusts, you	Protective (describe) job duties (yes/no) injury? work?	Were you workplace health (yes/no)
		☐ 40 or less ☐ more than 40					
		☐ 40 or less ☐ more than 40					
		☐ 40 or less ☐ more than 40					

Exposure Assessment Data: This section may not apply to all individuals.

Do you have any exposure assessment information from your work place or other area of concern (such as a place where you work on hobbies or crafts) with you today, or that is available to you? ☐ Yes ☐ No

Patient Number: ______________________________________ Staff Initials: ____________

Date: ____________________

If yes, describe. Please attach any copies with this form: _____
_____
_____

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Please answer the following about occupational and environmental exposures.	Better	Same	Worse	Please describe:
When off work or on vacation, is your condition better, the same, or worse?	□	□	□	
When you return to work after a weekend or vacation, is your condition better, the same, or worse? □ □ □ Is your condition better, the same, or worse after you have been back at work for several days or several shifts? □ □ □				
	Yes	No	Don't Know	If yes, please describe:
Has there been a change in the process, job responsibility, workplace configuration, or work environment? When did the change occur?	□	□	□	
Are your (or your spouse's or partner's) work clothes laundered at home? If not at home, where? What is your spouse's/partner's occupation.	□	□	□	
Do your work or hobby spaces have ventilation? Does it seem to work?	□	□	□	
Does protective equipment used at work or for hobbies fit you properly? Do you receive instructions for proper use and storage? Do you ever make changes in the equipment to make it more comfortable? Can you describe protective equipment you use?	□	□	□	fix or
On the job or during hobbies/craft activities, do you eat, smoke, and take your breaks? If so, when?	□	□	□	
Are animals (pets, livestock, birds or pests such as mice) present in your work or hobby environment or part of work or hobby tasks/activities? Have there been changes in their health, appearance, or behavior?	□	□	□	
Does someone else smoke in your residence or home? How much are your exposed to cigarette smoke?	□	□	□	
Is there a work-related union at your workplace that is involved in occupational safety and health issues?	□	□	□	
Do you work as a temporary, contract, day labor, or self-employed worker or do shift work/long work hours, a second job, or travel for work?	□	□	□	

Exposure and Chemical Inventory List: Please check all exposures and chemicals that you have come into direct contact with at a job or hobby/craft activity, or that you experience in your work or hobby setting. You can ask for Safety Data Sheets (SDS's) from your employer or craft/hobby supply provider to get this information. Please provide this information as best as you can. Not all chemical or exposure groups will apply to all individuals. You do not need to provide this information if you are not comfortable doing so. If you wish to provide this information when speaking directly with your physician or clinician, you may do so.

□ **Workday and environment**
□ Long/irregular work shifts
□ Work days ≥ 12 hours
□ Job stress
□ Workplace bullying
□ Workplace violence
□ Other_____
□ **Physical agents**
□ Awkward postures
□ Excess force
□ Heavy lifting
□ Noise
□ Excessive dampness
□ Heat stress
□ Cold stress
□ Vibration
□ Other_____
□ **Biological hazards**

□ **Organic dusts**
□ Cotton dust
□ Poison oak
□ Wood dust
□ Other _____
□ **Chemical mixtures**
□ Chemical waste mixtures
□ Cleaning agents
□ Disinfectants
□ Flavoring chemicals
□ Other _____
□ **Aerosols, irritants, gases**
□ Carbon monoxide
□ Ethylene oxide
□ Formaldehyde
□ Inert gases
□ Hydrogen sulfide

□ **Highly reactive substances**
□ Acids
□ Alkalis
□ Amines
□ Ammonia
□ Chlorine
□ Hydrazine
□ Phenols
□ Other _____
□ **Metals; metal fumes**
□ Aluminum
□ Arsenic, arsine
□ Beryllium
□ Cadmium
□ Chromium
□ Cobalt
□ Iron

□ **Welding and related emissions (some listed twice)**
□ Cadmium
□ Copper
□ Lead
□ Nickel
□ Nitrogen oxides
□ Ozone
□ Zinc
□ Other _____
□ **Solvents**
□ Benzene, benzene derivatives
□ 1-Bromopropane
□ 1,3 Butadiene
□ Diethanolamine
□ Glutaraldehyde
□ Methylene chloride
□ Perchloroethylene ("perc")

□ **Dyes and stains**
□ Aniline and/or Azo dyes
□ Benzidine
□ Other coatings, surface treatments
□ Other _____
□ **Pesticides**
□ Carbamates
□ Organochlorines
□ Organophosphates
□ Phenoxyherbicides
□ Pyrethroids
□ Other _____
□ **Plastics, Polymers, Composites, Monomers**
□ Acrylonitrile
□ Aliphatic amines
□ Epoxy resins

□ **Petrochemicals**
□ Asphalt and tar
□ Creosote
□ Coal tar
□ Dioxins and furans
□ polybrominated biphenyls-PBBs
□ polychlorinated biphenyls-PCBs
□ Petroleum distillates
□ Hydrogen sulfide
□ Fuels, jet fuels
□ Other _____
□ **X-rays, radiation**
□ Infrared
□ Lasers
□ Microwaves
□ Radio-isotopic wastes
□ Radionuclides, including radon

□ Bacteria
□ Fungi, molds
□ Viruses
□ Toxins

□ Nitrogen sulfide
□ Ozone
□ Phosgene
□ Sewer gas (mainly hydrogen sulfide)

□ Lead
□ Mercury
□ Other _____
□ **Man-made materials**
□ Silica

□ Toluene
□ Trichloroethane
□ Trichlorethylene ("trike")
□ Xylene(s)
□ Other _____

□ Phthalates
□ Styrene
□ Toluene diisocyanate (TDI)
□ Vinyl chloride
□ Other _____

□ Ultraviolet light
□ X-rays
□ Other _____
Others not on this list:

□ Biohazard waste
□ Blood, body fluids
□ Other _____

□ Smoke
□ Sulfur dioxide
□ Other _____

□ Talc
□ Nanomaterials
□ Other _____

□ **Inorganic dusts and powders**
□ Asbestos
□ Fiberglass

□ Coal dust
□ Other _____

Patient Number: _____

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History of Present Illness: This section to be completed by physician or clinician.

Physical Exam Findings: This section to be completed by physician or clinician.

Laboratory, Radiology and Other Test Results: This section to be completed by physician or clinician.

Assessment and Plan: This section to be completed by physician or clinician.

Physician/Clinician signature/date: _____

Patient Number: _____ Staff Initials:

_____

Date: ___