HealthPartners®
Occupational & Environmental Medicine

RESET FORM

Initial Health Questionnaire

Your company has asked us to perform a physical examination, with your permission, in regard to your employment. As part of that examination, we ask for your cooperation in filling out this questionnaire.

Try to answer all the questions to the best of your ability but don't worry too much about details. The examining physician will review this questionnaire and you will have an opportunity then to clarify your answers and add any necessary details.

Sometimes the questionnaire may seem repetitive. Please answer the questions anyway even if you think you already supplied those answers elsewhere in the questionnaire. Different parts of the questionnaire are designed for different purposes and we sometimes need to ask about the same thing – though usually from a different "angle".

You may have some concerns about answering questions of a personal nature during this examination. The doctor does need to know as much about you as possible to do the best job. It is impossible to determine beforehand what may be relevant information in a medical situation. However, you are guaranteed by our Policy and Procedure and by Federal Law that your employer will only receive information strictly related to your job duties unless you specifically authorize further release of information.

If you have any questions, please feel free to ask any of our staff.

Date of Exam _____

Name: Last _____ First _____ Middle _____

Sex _____ Date of Birth _____

Job Title _____ Employer _____

How many years in this job? _____ How many years with this employer? _____

Occupational Medicine 952-883-6999

St. Paul Clinic:
205 S Wabasha St.,
Saint Paul, MN 55107

Riverside Clinic:
2220 Riverside Ave.,
Minneapolis, MN 55454

West Clinic:
5100 Gamble Dr Ste 100,
Saint Louis Park, MN 55416

THIS INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR EXPRESSED PERMISSION

Symptom History (please check the box for any of these you have now or have ever had)

Head & Neck
- ☐ Concussion
- ☐ Frequent Headache
- ☐ Whiplash
- ☐ Frequent Neck Pain
- ☐ Frequent Stiff Neck
- ☐ Frequent Swollen Glands

Eyes
- ☐ Blurred Vision
- ☐ Tunnel Vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Vision Loss
- ☐ Frequent Irritation

Ears
- ☐ Hearing Loss
- ☐ Frequent Earache
- ☐ Buzzing/Ringing in Ears
- ☐ Motion Sickness
- ☐ Frequent Discharge

Nose & Throat
- ☐ Sinus Trouble
- ☐ Frequent Nose Bleeds
- ☐ Frequent Sore Throat
- ☐ Frequent Hoarseness
- ☐ Trouble Swallowing
- ☐ Loss of Taste
- ☐ Loss of Smell

Mouth
- ☐ Sores
- ☐ Bleeding Gums

Lungs
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Shortness of Breath While Walking
- ☐ Persistent Sputum/Phlegm
- ☐ Asthma
- ☐ Frequent Wheezing
- ☐ Hayfever

Blood
- ☐ Anemia
- ☐ Tremor
- ☐ Bleeding Problems

Heart
- ☐ Rheumatic Fever
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Swollen Ankles
- ☐ Heart Attack

Digestive
- ☐ Frequent Heart Burn
- ☐ Frequent Stomach Pain
- ☐ Frequent Nausea
- ☐ Frequent Vomiting
- ☐ Frequent Diarrhea
- ☐ Frequent Constipation
- ☐ Jaundice
- ☐ Liver Problems
- ☐ Gallstones
- ☐ Ulcers
- ☐ Black Stools
- ☐ Rectal Bleeding
- ☐ Hemorrhoids

Metabolic
- ☐ Gout
- ☐ Diabetes
- ☐ Thyroid Problem
- ☐ Unexplained Weight Loss/Gain
- ☐ Loss of Appetite

Kidney
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Kidney or Bladder Infections
- ☐ Pain with Urination
- ☐ Blood in Urine

Skin
- ☐ Persistent Sores or Rash
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Rash from Contact or Allergy

Neuro
- ☐ Stroke
- ☐ Seizures
- ☐ Loss of Memory
- ☐ Paralysis
- ☐ Persistent Weakness
- ☐ Loss of Consciousness

Neuro (*continued*)
- ☐ Dizziness
- ☐ Persistent Numbness/Tingling

Mental State
- ☐ Severe Insomnia
- ☐ Depression
- ☐ Feeling Unable to Cope
- ☐ Chemical Dependency
- ☐ Nervous Breakdown

Musculoskeletal
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Back Pain
- ☐ Slipped Disc
- ☐ Dislocation
- ☐ Broken Bone

Pain/Swelling of
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Finger
- ☐ Hip
- ☐ Knee
- ☐ Ankle

Infections
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ German Measles/Rubella
- ☐ Mumps

Male Only
- ☐ Impotence
- ☐ Infertility
- ☐ Swelling of Breasts
- ☐ Lump on Testicle

Female Only
- ☐ Menstrual Disorder
- ☐ Infertility
- ☐ Lump on Breast

☐ **NONE OF THE ABOVE APPLY**

Past Medical History

1. Have you ever had any surgeries? ☐ Yes ☐ No

If so, when and what _____

_____

_____

2. Have you ever been admitted to a hospital? ☐ Yes ☐ No

If so, when and for what? _____

_____

_____

3. Do you have any allergies to medications? ☐ Yes ☐ No

If so, please list _____

_____

_____

4. Do you have any allergies to food? ☐ Yes ☐ No

If so, please list _____

_____

_____

5. Do you ever get hives, asthma, allergic skin rashes? ☐ Yes ☐ No

6. Are you currently taking any medications, either by prescription or over-the-counter? ☐ Yes ☐ No

If so, please list _____

_____

_____

7. Are you currently seeing a health care provider for any medical problems? ☐ Yes ☐ No

If so, who and what? _____

_____

_____

8. Who is your current private physician? _____

Personal Health Habits

1. Do you use tobacco? ☐ Yes ☐ No

Any use of tobacco can best be described as: (Check one)

- ☐ Cigars or pipe only
- ☐ Up to 1/2 pack of cigarettes per day
- ☐ 1/2 to 1 1/2 pack of cigarettes per day
- ☐ 1 1/2 to 3 packs of cigarettes per day
- ☐ More than 3 packs of cigarettes per day
- ☐ Snuff or chewing tobacco

2. Did you formerly smoke cigarettes? ☐ Yes ☐ No

If so, when did you quit? _____

How long did you smoke? _____

How many packs per day? _____

3. Do you drink alcohol? ☐ Yes ☐ No

How often do you drink alcohol?

- ☐ Less than once a week
- ☐ 1 to 3 times a week
- ☐ 3 to 5 times a week
- ☐ Nearly every day

When you drink, how many do you typically have?

- ☐ 1-3 drinks
- ☐ 4-6 drinks
- ☐ More than 6 drinks

4. Do you have yearly physical check-ups? ☐ Yes ☐ No

5. Do you wear a seat belt when you drive? ☐ Yes ☐ No

6. Have you been immunized against? (Check all that apply)

- ☐ Tetanus
- ☐ Pertussis
- ☐ Measles
- ☐ Rubella
- ☐ Hepatitis
- ☐ Diphtheria
- ☐ Polio
- ☐ Mumps
- ☐ Tuberculosis

7. Do you have your cholesterol measured? ☐ Yes ☐ No

What was your last cholesterol level? _____

8. Do you exercise outside of work activities for 20 minutes three times a week? ☐ Yes ☐ No

Work History

1. Have you ever worked in any of the following industries?

(Check all that apply and mark down for how long you worked in each)

- ☐ Mining _____
- ☐ Quarrying _____
- ☐ Stone cutting _____
- ☐ Foundry _____
- ☐ Pottery _____
- ☐ Printing _____
- ☐ Textiles _____
- ☐ Oil refinery _____
- ☐ Meatpacker _____
- ☐ Trucking _____
- ☐ Farming _____
- ☐ Battery manufacture _____
- ☐ Car body repair _____
- ☐ Sand blasting _____
- ☐ Welding _____
- ☐ Plastic manufacture _____
- ☐ Glass manufacture _____
- ☐ Rubber manufacture _____
- ☐ Chemical plant _____
- ☐ Pulp/paper mill _____
- ☐ Logging _____
- ☐ Cotton, flax, hemp manufacture _____

2. Have you ever worked with any of the following?

(Check all that apply and mark down for how long you worked with each)

- ☐ Asbestos _____
- ☐ Fiberglass _____
- ☐ Rock wool _____
- ☐ Cutting oils _____
- ☐ Solvents _____
- ☐ Pesticides _____
- ☐ Isocyanates _____
- ☐ Mercury _____
- ☐ Paints _____
- ☐ Herbicides _____
- ☐ Arsenic _____
- ☐ Lasers _____
- ☐ Microwaves _____
- ☐ Lead _____
- ☐ Radioactive materials _____
- ☐ Loud noise _____
- ☐ Pneumatic tools _____
- ☐ Vibrating tools _____
- ☐ Formaldehyde _____
- ☐ Lacquers _____
- ☐ Insecticides _____

3. Have you developed a hearing loss from exposure to loud noise? ☐ Yes ☐ No

4. Have you ever developed any health problems from exposure to chemicals, dusts, or fumes? ☐ Yes ☐ No

5. Have you developed any chronic back pain or arm pain as a result of work? ☐ Yes ☐ No

6. Do you feel you have any health problems as a result of your current job or any previous jobs? ☐ Yes ☐ No

If so, please list _____

_____

_____

7. Do you have any concerns or questions about any exposures at your current job or any previous jobs? ☐ Yes ☐ No

If so, please list _____

_____

_____

Disability History

1. Do you feel you have any disability, handicap or limitations on your activities? ☐ Yes ☐ No

If so, please list _____

_____

_____

2. Have you ever been denied a job for health reasons? ☐ Yes ☐ No

If so, why? _____

_____

_____

3. Have you ever been denied life insurance? ☐ Yes ☐ No

If so, why? _____

_____

_____

4. Have you ever been paid a disability benefit? ☐ Yes ☐ No

If so, why? _____

_____

_____

5. Have you been advised by a doctor to permanently limit your activities in any way? ☐ Yes ☐ No

If so, why? _____

_____

_____

Injury History

1. Have you ever been injured playing sports? ☐ Yes ☐ No

If so, when and how? _____

_____

_____

2. Have you ever been injured at home? ☐ Yes ☐ No

If so, when and how? _____

_____

_____

3. Have you ever been injured in an accident involving a vehicle: ☐ Yes ☐ No

car, motorcycle, boat, snowmobile, bicycle, etc.

If so, when and how? _____

_____

_____

4. Were you injured in military service? ☐ Yes ☐ No

If so, when and how? _____

_____

_____

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

If so, when and how? _____

_____

_____

Absestos/Silica - Supplement

1. If you get a cold does it usually go to your chest? ☐ Yes ☐ No

2. In the last three years have you had any chest illnesses that have kept you off work, in doors at home or in bed? ☐ Yes ☐ No

If so, did you produce phlegm? ☐ Yes ☐ No

How many such illnesses have you had? _____

3. Did you have any lung trouble before age 16? ☐ Yes ☐ No

4. Have you ever had any of the following and at what age? (Check all that apply)

Condition	Age	Confirmed by doctor	Condition	Age	Confirmed by doctor
☐ Bronchitis	____	☐ Yes ☐ No	☐ Chronic bronchitis	____	☐ Yes ☐ No
☐ Pneumonia	____	☐ Yes ☐ No	☐ Emphysema	____	☐ Yes ☐ No
☐ Hay fever	____	☐ Yes ☐ No	☐ Asthma	____	☐ Yes ☐ No

5. Have you ever had any of the following? (Check all that apply)

☐ Other chest illnesses
☐ Chest operation
☐ Chest injuries

6. Do you usually have a cough? ☐ Yes ☐ No

On getting up first thing in the morning? ☐ Yes ☐ No
At all during the rest of the day? ☐ Yes ☐ No
4-6 times a day at least 4 days a week? ☐ Yes ☐ No
At night during sleep? ☐ Yes ☐ No
On most days for at least 3 months in a row? ☐ Yes ☐ No
How many years have you had a cough? ____

7. Do you usually bring up phlegm from your chest? ☐ Yes ☐ No

On getting up first thing in the morning? ☐ Yes ☐ No
At all during the rest of the day? ☐ Yes ☐ No
4-6 times a day at least 4 days a week? ☐ Yes ☐ No
At night during sleep? ☐ Yes ☐ No
On most days for at least 3 months in a row? ☐ Yes ☐ No
How many years have you had a cough? ____

8. Does your chest ever sound wheezy or whistling? ☐ Yes ☐ No

Only when you have a cold? ☐ Yes ☐ No
Other times too? ☐ Yes ☐ No
Most of the time? ☐ Yes ☐ No
Has it ever mad you feel short of breath? ☐ Yes ☐ No
Have you ever required medical treatment? ☐ Yes ☐ No
How old were you when the wheezing started? ☐ Yes ☐ No

6. Do you get short of breath walking fast or walking up a hill? ☐ Yes ☐ No

6. What has been your previous exposure to? (Check all that apply)

Dusts	☐ none	☐ mild	☐ moderate	☐ severe	Fumes/vapor	☐ none	☐ mild	☐ moderate	☐ severe
Noxious gasses	☐ none	☐ mild	☐ moderate	☐ severe	Chemicals	☐ none	☐ mild	☐ moderate	☐ severe