Holland Medicenter
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HAZMAT Medical History Form

Employee Name:________________________________ DOB: ____________ Age:_______ SSN:________________

Employer Name:____ Date of Service:____________________

1. Have you ever been in the hospital as a patient? ☐ Yes ☐ No
2. Have you ever had any kind of operation/surgery? ☐ Yes ☐ No
3. Do you take any medicine regularly? ☐ Yes ☐ No
4. Are you allergic to any drugs, foods, or chemicals? ☐ Yes ☐ No
5. Have you ever been told that you have any of the following?

Asthma	☐ Yes	☐ No	Cirrhosis	☐ Yes	☐ No
Hayfever	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Sinusitis	☐ Yes	☐ No	Other respiratory problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Arthritis/joint pain	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Heart attack or heart trouble	☐ Yes	☐ No

6. Have you been under the care of a physician during the past year? ☐ Yes ☐ No
7. Is there any change in your breathing in the last year? ☐ Yes ☐ No
8. Is your general health different this year from last year? ☐ Yes ☐ No
9. Do you smoke? ☐ Yes ☐ No
10. Do you drink alcohol in any form? ☐ Yes ☐ No
11. Do you wear glasses or contacts? ☐ Yes ☐ No

Occupational History

1. How long have you worked for your present employer? _____
2. What jobs have you held with this employer? Please include job title and length of time in each job.

____
____

3. In each of these jobs, how many hours per day were you exposed to chemicals?

____

4. What chemicals have you worked with most of the time?____

____

5. Have you ever noticed any type of skin rash you feel was related to your work? ☐ Yes ☐ No
6. Have you every noticed any kind of chemical makes you cough, be short of breath, or wheeze? ☐ Yes ☐ No

7. Are you exposed to any dust or chemicals at home? ☐ Yes ☐ No

8. In other jobs, have you ever had exposure to:

Wood dust	☐ Yes	☐ No	Nickel	☐ Yes	☐ No
Silica	☐ Yes	☐ No	Arsenic/Asbestos	☐ Yes	☐ No
Organic solvents	☐ Yes	☐ No	Urethane foams	☐ Yes	☐ No

Symptoms Questionnaire

1. Do you ever have any shortness of breath? ☐ Yes ☐ No

If Yes... Do you have to rest after climbing several flights of stairs? ☐ Yes ☐ No

If you walk with people your own age, do you walk slower than they? ☐ Yes ☐ No

If you walk slower, do you have to limit the distance you walk? ☐ Yes ☐ No

Do you have to stop and rest while bathing or dressing? ☐ Yes ☐ No

2. Do you cough as much as three months out of the year? ☐ Yes ☐ No

If Yes... Have you had this cough for more than 2 years? ☐ Yes ☐ No

Do you ever cough anything up from your chest? ☐ Yes ☐ No

3. Do you ever have a feeling of smothering, unable to take a deep breath or tightness in your chest? ☐ Yes ☐ No

If Yes... Do you notice this on any particular day of the week? ☐ Yes ☐ No
If so, what day of the week?____

Do you notice that it occurs at any particular place? ☐ Yes ☐ No

Do you notice it is worse after going back to work after being off? ☐ Yes ☐ No

4. Have you ever noticed wheezing in your chest? ☐ Yes ☐ No

If Yes... Is this only with colds or other infections? ☐ Yes ☐ No

Is this caused by exposure to any kind of dust or other material? ☐ Yes ☐ No

5. Have you ever had...

Phlebitis or pleurisy	☐ Yes	☐ No	Vertigo	☐ Yes	☐ No
A stroke	☐ Yes	☐ No	Ringing in the ears	☐ Yes	☐ No

Breathing difficulty when lying down without a pillow ☐ Yes ☐ No

Tightness, pain, heaviness, squeezing, or pressure around your heart ☐ Yes ☐ No

6. Have you noticed any burning, tearing, or redness of your eyes while at work? ☐ Yes ☐ No

7. Have you noticed any sore or burning throat or itchy/burning nose while at work? ☐ Yes ☐ No

8. Have you notice any stuffiness or dryness of your nose? ☐ Yes ☐ No

9. Do you have any swelling of the eyelids or face? ☐ Yes ☐ No

10. Have you ever been jaundiced ☐ Yes ☐ No

11. Have you ever bruised easily or bleed excessively? ☐ Yes ☐ No

12. Do you have frequent headaches that are not relieved by Aspirin or Tylenol? ☐ Yes ☐ No

13. Do you have frequent episodes of nervousness or irritability? ☐ Yes ☐ No

14. Do you tend to have trouble concentrating or remembering? ☐ Yes ☐ No

15. Do you ever feel dizzy, light-headed, or excessively drowsy? ☐ Yes ☐ No

16. Does your vision ever become blurred? ☐ Yes ☐ No

17. Do you have numbness or tingling of the hands or feet or other parts of your body? ☐ Yes ☐ No

18. Have you ever had chronic weakness or fatigue? ☐ Yes ☐ No

19. Have you ever had any swelling of your feet or ankles? ☐ Yes ☐ No

20. Are you bothered by heartburn or indigestion? ☐ Yes ☐ No

21. Do you ever have itching, dryness, scaling, or peeling of the hands? ☐ Yes ☐ No

22. Do you ever have a burning sensation in the hands or reddening of the skin? ☐ Yes ☐ No

23. Do you ever have creacking or bleeding of the skin of the hands? ☐ Yes ☐ No

24. Do you have any physical complaints today? ☐ Yes ☐ No
    If so, what?____

25. Do you have any other health conditions not covered by these questions? ☐ Yes ☐ No
    If so, what?____.

____

I hereby certify that to the best of my knowledge the foregoing answers are complete and correct and I understand that any false statement or incorrect information may result in my termination. I agree that this form and any information acquired as a result of this examination will become property of the employer. I hereby grant permission to obtain records from all physician(s) or hospital(s) where I have been or am receiving treatment, as it pertains to my HAZMAT physical. I authorize Holland Medicenter and it's staff to release a copy of this medical questionnaire to my employer.

____ ____________________________

Patient Signature Date