



**MEDICAL HISTORY INFORMATION  
FOR CHEMICAL WASTE EXPOSURE**

Employer: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Job Title or Category: \_\_\_\_\_ Years at Present Job: \_\_\_\_\_

Job Description – In fifty words or less, please describe your current job: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Regular Workplace: \_\_\_\_\_  
(location) (division)

Have you ever worked with any of the following material, or under any of the conditions listed below? (*check only if you have worked with or under these conditions*)

- |  |  |
|--|--|
| <input type="checkbox"/> Asbestos  | <input type="checkbox"/> Silica (e.g. sandblasting)        |
| <input type="checkbox"/> Tungsten/cobalt/(e.g. grinding<br>or welding this material) | <input type="checkbox"/> Beryllium                         |
| <input type="checkbox"/> Aluminum  | <input type="checkbox"/> Coal (e.g. mining)                |
| <input type="checkbox"/> Iron  | <input type="checkbox"/> Tin                               |
| <input type="checkbox"/> Dusty environments  | <input type="checkbox"/> Any other hazardous<br>exposures? |

Explain any exposures listed above:

\_\_\_\_\_  
\_\_\_\_\_

List any second jobs or side business you have: \_\_\_\_\_

List any previous occupations: \_\_\_\_\_

\_\_\_\_\_  
List your current and previous hobbies: \_\_\_\_\_

Hazardous Waste Questionnaire

**Sex:** Male ( ) Female ( ) **Marital Status:** Married ( ) Single ( ) Divorced ( )

Occupational History

1. Have you ever worked with benzene, lead, arsenic, mercury, degreasers, solvents, insecticides, fungicides or other compounds that can cause diseases of the blood, marrow or lymph nodes? If yes please complete the section below.

<i><u>Company</u></i>	<i><u>Job Category</u></i>	<i><u>Type of Chemical Exposure</u></i>	<i><u>% of Time Exposed</u></i>	<i><u>Years Employed</u></i>
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2. Any leukemia, anemias, cancer or other blood abnormalities in **blood relatives**?

Yes \_\_\_\_\_ No \_\_\_\_\_ **If yes, please explain:** \_\_\_\_\_

3. Have **you** ever had any blood abnormalities such as an anemia, abnormal blood cells, free bleeding, excessive bleeding after surgery or dental work, or gums that bleed easily?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

4. Have you ever had kidney or liver problems other than occasional bladder infections?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

5. What medicines are you taking regularly/daily? \_\_\_\_\_

6. Have you been exposed to or have you worked with X-rays, therapeutic radiation other than for diagnosis? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain? \_\_\_\_\_

7. Do you come in contact with solvents, degreasers, insecticides, fungicides, lead, mercury or arsenic compounds outside of your present workplace? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

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**Please answer the following questions by checking the applicable blocks:**

Have you ever been hospitalized? Yes ( ) No ( )  
If yes, please list dates and give details: \_\_\_\_\_

Have you ever been operated on? Yes ( ) No ( )  
If yes, please list dates and give details: \_\_\_\_\_

Have you ever been outside the United States? Yes ( ) No ( )  
If yes, please list locations and dates: \_\_\_\_\_

Indicate any occupational illness or injuries you have experienced since being employed in your  
-present job: \_\_\_\_\_

\_\_\_\_\_

-prior job: \_\_\_\_\_

Have you had or do you have now any of the following illnesses or conditions? If so, please check the appropriate block(s):

- |   |   |
|---|---|
| <input type="checkbox"/> Abnormal bleeding          | <input type="checkbox"/> Jaundice                     |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Kidney trouble or stones     |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Leukemia                     |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Malaria                      |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Migraine                     |
| <input type="checkbox"/> Cirrhosis of the liver     | <input type="checkbox"/> Mumps                        |
| <input type="checkbox"/> Dermatitis                 | <input type="checkbox"/> Nephritis (Bright's Disease) |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Nervous Breakdown            |
| <input type="checkbox"/> Dizziness or fainting      | <input type="checkbox"/> Neuritis                     |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Paralysis of any type        |
| <input type="checkbox"/> Erysipelas                 | <input type="checkbox"/> Piles or hemorrhoids         |
| <input type="checkbox"/> Gallbladder disease/stones | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Polio                        |
| <input type="checkbox"/> Gonorrhea                  | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Gout                       | <input type="checkbox"/> Scarlet Fever                |
| <input type="checkbox"/> Hay Fever                  | <input type="checkbox"/> Swollen Joints               |
| <input type="checkbox"/> Heart Attack               | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Syphilis                     |
| <input type="checkbox"/> Hernia or rupture          | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Ulcer (stomach/duodenal)     |
| <input type="checkbox"/> Hives                      |   |

Hazardous Waste Questionnaire

In the past year have you or your spouse had:

1. any problems with fertility or with becoming pregnant (trying for at least one year)?  
Yes ( ) No ( )
2. any miscarriages?  
Yes ( ) No ( )
3. a premature baby (born under 5 pounds or before the 8<sup>th</sup> month)?  
Yes ( ) No ( )
4. a live birth  
Yes ( ) No ( )
5. a loss of an infant (stillbirth and/or up to one month of age)?  
Yes ( ) No ( )
6. any problems with a child (birth defect, serious illness, loss)?  
Yes ( ) No ( )

Do you have or are you concerned about any of the following: (If so, please check the appropriate box or boxes)

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies                          | <input type="checkbox"/> Hemorrhoids (piles)                         |
| <input type="checkbox"/> Back Pain                          | <input type="checkbox"/> Hives                                       |
| <input type="checkbox"/> Blood in urine, sputum or stool    | <input type="checkbox"/> Hot flashes                                 |
| <input type="checkbox"/> Blood Pressure                     | <input type="checkbox"/> Kidney Problems                             |
| <input type="checkbox"/> Bowel Problems                     | <input type="checkbox"/> Joint Pains                                 |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Leg Cramps                                  |
| <input type="checkbox"/> Chest Pain                         | <input type="checkbox"/> Liver problems                              |
| <input type="checkbox"/> Chronic cough                      | <input type="checkbox"/> Loss of memory                              |
| <input type="checkbox"/> Cold or painful fingers            | <input type="checkbox"/> Lung or breathing difficulty                |
| <input type="checkbox"/> Constipation                       | <input type="checkbox"/> Menopause                                   |
| <input type="checkbox"/> Depression or excessive worry      | <input type="checkbox"/> Muscle aches or pains                       |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Nervousness                                 |
| <input type="checkbox"/> Diarrhea                           | <input type="checkbox"/> Sexual Problems                             |
| <input type="checkbox"/> Difficulty in sleeping             | <input type="checkbox"/> Sickle cell disease or trait                |
| <input type="checkbox"/> Dizziness                          | <input type="checkbox"/> Skin Disease                                |
| <input type="checkbox"/> Ear or hearing problems            | <input type="checkbox"/> Stomach pain                                |
| <input type="checkbox"/> Edema (foot or leg swelling)       | <input type="checkbox"/> Swollen glands                              |
| <input type="checkbox"/> Eye Trouble (other than glasses)   | <input type="checkbox"/> Thyroid Gland problem                       |
| <input type="checkbox"/> Fainting spells or unconsciousness | <input type="checkbox"/> Tumors or cysts                             |
| <input type="checkbox"/> Fever                              | <input type="checkbox"/> Unexpected weight loss/gain (please circle) |
| <input type="checkbox"/> Frequent or severe headaches       | <input type="checkbox"/> Venereal disease                            |
| <input type="checkbox"/> Heart condition                    | <input type="checkbox"/> Heart Murmur                                |
| <input type="checkbox"/> Tremor of hands or head            | <input type="checkbox"/> Unusual weakness                            |

Have you had a chest x-ray within the last 2 years? Yes ( ) No ( )

Hazardous Waste Questionnaire

If yes, please list doctor/hospital name and address: \_\_\_\_\_

Family History

Indicate any blood relative who ever had any of the following:

Disease	Mother	Father	Grandparent	Sister/Brother	Children
Anemia (low iron)					
Arthritis					
Allergy					
Alcoholism					
Bleeding Disorder					
Congenital Malformation					
Cancer					
Diabetes (high sugar)					
Emphysema/lung disorder					
Epilepsy (seizures)					
Glaucoma					
Gout					
Heart Attack					
High Blood Pressure					
Kidney Disease					

Family History Continued:

Indicate any blood relative who ever had any of the following:

Disease	Mother	Father	Grandparent	Sister/Brother	Children
Kidney Stones					
Gall Bladder					
Mental Illness					
Mental Retardation					
Sickle Cell					
Stomach Ulcers					
Stroke					
Tuberculosis					

If either of your parents are not living, list their age at death and cause of death, if known.

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Are you aware of any disease or illnesses that run in your family? Yes ( ) No ( )

If yes, please list: \_\_\_\_\_

Do you drink alcoholic beverages? Yes ( ) No ( ) If yes, please indicate type of alcohol consumed and amount per day? \_\_\_\_\_

Do you smoke? Yes ( ) No ( ) If yes, please indicate type of tobacco (cigar, cigarette, pipe, etc.) and amount per day and how long \_\_\_\_\_

If you smoked previously but have since quit please indicate when you quit, how much you smoked, how long and type of tobacco prior to quitting \_\_\_\_\_

Please describe your hobbies, particularly those involving use of chemicals or noise.

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### Medication History

Are you now taking or have you taken any of the following within the past month?

- |  |   |
|--|---|
| <input type="checkbox"/> Antacids              | <input type="checkbox"/> Digitalis                          |
| <input type="checkbox"/> Antibiotics           | <input type="checkbox"/> Diuretics                          |
| <input type="checkbox"/> Anticoagulants        | <input type="checkbox"/> Hormones                           |
| <input type="checkbox"/> Antidepressants       | <input type="checkbox"/> Insulin or oral antidiabetic drugs |
| <input type="checkbox"/> Antihistamines        | <input type="checkbox"/> Laxatives                          |
| <input type="checkbox"/> Appetite Suppressants | <input type="checkbox"/> Morphine                           |
| <input type="checkbox"/> Aspirin               | <input type="checkbox"/> Sleeping Pills                     |
| <input type="checkbox"/> Birth Control Pills   | <input type="checkbox"/> Sulfa Preparations                 |
| <input type="checkbox"/> Benzedrine            | <input type="checkbox"/> Thyroid                            |
| <input type="checkbox"/> Blood Pressure        | <input type="checkbox"/> Tranquilizers                      |
| <input type="checkbox"/> Cortisone             | <input type="checkbox"/> Vitamins                           |
| <input type="checkbox"/> Codeine               | <input type="checkbox"/> Dexedrine                          |

List any drugs you have taken regularly:

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Have you been on any special diet(s) in the past year?

- Yes       No *If yes, please describe type:* \_\_\_\_\_

Are you allergic to any of the following:

- Pollens
- House Dust
- Animal Dander, feathers, or fur
- Drugs
- Vaccines
- Serum
- Metal, Jewelry
- Foods
- Sunlight or cold
- Insect bites

If yes, please list type of reaction. \_\_\_\_\_

Immunizations, Vaccines, Antitoxins, etc.

Check if you have received any of the following: (give approximate date(s) when last received, if known)

Hazardous Waste Questionnaire

<b>Vaccine</b>	<b>Date(s)</b>
Tetanus	
Poliomyelitis	
Influenza	
Typhoid	
Diphtheria	
Rabies	
Rubella	
Measles	
BCG	
Yellow fever	
Small Pox	
RhoGam (RH immune globulin)	
Immune serum globulin for hep.	
Other (please list)	
Mantoux (TB skin test)	Result (+) or (-)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_