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Woburn, Massachusetts 01801-6350
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*General Medical Questionnaire

Try to answer all questions as accurately as possible.

Name: (Last, First, Middle)			**Date:(mm/dd/yr)**
Address:	**City:**	**State:**	**Zip Code:**
Name of Employer:			
Address:	**City:**	**State:**	**Zip Code:**
Address 2:	**Personal Email:**		
Job Title:	**Employee ID #:**		**Last Four Digits of SS#:XXX-XX-**
Date of Birth: (mm/dd/yr)			
Home Phone:	**Cell Phone:**		**Business Phone:**

Type of Exam:

- ☐ Executive
- ☐ Pre-Placement
- ☐ Medical Surveillance
- ☐ Other_____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I certify that the answers below are true and correct to the best of my recollection.

Employee Signature:_____Date:_____

Medical Reviewer Signature:_____Date:_____

***This questionnaire meets the requirements of the OSHA Respiratory Protection Standard (29CFR 1910.134 AppC) questionnaire for Part A Section 1 and 2.**

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MEDICAL HISTORY

PERSONAL HISTORY

Marital Status ☐ Married ☐ Divorced	☐ Single ☐ Separated ☐ Widowed	Gender: Male ☐ Female ☐	Number of Children	Country of Birth

Do you smoke? ☐ Yes ☐ No	#packs smoked/day	Have you smoked in the past? ☐ Yes ☐ No	#Yrs. Smoked	Quit Date:	How many times per week do you exercise? Type of Exercise:

Do you use smokeless tobacco? ☐ Yes ☐ No	Amount used per day?	Have you used smokeless tobacco in the past? ☐ Yes ☐ No	# of Years:	Quit Date:

Do you ever drink alcoholic beverages? ☐ Yes ☐ No	If yes, how many servings do you have in a week?	When was your last drink?
Have you ever had a drug or alcohol problem? ☐ Yes ☐ No	If yes, explain:	

Are you right handed? ☐ left handed? ☐ ambidextrous? ☐

OCCUPATIONAL HISTORY

Usual Occupation:	Present Job describe- work activities:	Number of years at present occupation:
Have you ever been injured at work? ☐ Yes ☐ No	If yes, give date and describe:	

MILITARY SERVICE: ☐ Yes ☐ No

FOREIGN TRAVEL IN PAST YEAR: ☐ Yes ☐ No If YES, list countries:

PRESENT MEDICATIONS

Drug	Dose/Time	Drug	Dose/Time	ALLERGIES (Medication & Environmental)
1 .		5.		
2.		6.		
3.		7.		
4.		8.		

Have you ever had any of the following? (check appropriate boxes)

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Angina
- ☐ Kidney Disease
- ☐ Sleep Apnea
- ☐ Claustrophobia (fear of enclosed spaces)
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis (TB)
- ☐ Lung Cancer
- ☐ Broken Ribs
- ☐ Chronic Bronchitis
- ☐ Psychiatric Disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Bleeding Disorder
- ☐ Arthritis
- ☐ Seizures
- ☐ Allergic Reactions that interfered with breathing
- ☐ Asbestosis
- ☐ Emphysema
- ☐ Silicosis
- ☐ Preumthorax (collapsed lung)
- ☐ Chest Injuries or Surgeries
- ☐ Other Lung Problems
- ☐ Heart Failure
- ☐ Swelling in Legs or Feet
- ☐ Heart Arrhythmia (heartbeat irregular)

Hospitalizations/Operations	Complications	Year	Hospital
1.			
2.			
3.			

Accidents/Injuries (i.e., broken bones/fractures, sprains, strains, including cartilage & ligament injuries). Describe and Date:

1.
2.
3.

Comments and/or Explanations: _____

_____

Examiner Comments: _____

_____

_____

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REVIEW OF SYSTEMS

Do you have an existing and/or recent problem with:

			Yes	No
General	Insomnia	1.	☐	☐
	Daytime Drowsiness	2.	☐	☐
	Anemia	3.	☐	☐
	Fevers	4.	☐	☐
	Recent loss/gain in past 6 months	5.	☐	☐
	Night Sweats	6.	☐	☐
	Swollen glands	7.	☐	☐
	Swelling in your groin or armpit	8.	☐	☐
	Fatigue	9.	☐	☐
Skin	Rashes or skin allergies	10.	☐	☐
	Poor Healing	11.	☐	☐
	Easy bruising	12.	☐	☐
	Change in lumps/moles	13.	☐	☐
Eyes	Blurring vision	14.	☐	☐
	Double Vision	15.	☐	☐
	Eye pain or irritation	16.	☐	☐
	Ever lost vision in either eye	17.	☐	☐
	Cataracts	18.	☐	☐
	Glaucoma	19.	☐	☐
	Wear glasses/contacts	19.	☐	☐
	Color	20.	☐	☐
Ears	Wear hearing aid	21.	☐	☐
	Ringing in ears	22.	☐	☐
	Deafness/trouble hearing	23.	☐	☐
	Ear Infections	24.	☐	☐
	Injury to ears	25.	☐	☐
	Broken ear drum	26.	☐	☐
	Any other ear problem	27.	☐	☐
Nose	Snoring	28.	☐	☐
	Sinus Infections	29.	☐	☐
	Bleeding	30.	☐	☐
	Nasal congestion without a cold	31.	☐	☐
	Trouble smelling odors	32.	☐	☐
Throat	Infections/Strep	33.	☐	☐
	Hoarseness	34.	☐	☐
	Trouble Swallowing	35.	☐	☐
Endocrine	Thyroid problems	36.	☐	☐
	Cold intolerance	37.	☐	☐
	Heat intolerance	38.	☐	☐
	Excessive thirst	39.	☐	☐
	Excessive hunger	40.	☐	☐
Oral	Gums bleed easily.	41.	☐	☐
	Dental Problems	42.	☐	☐
	Sense of taste	43..	☐	☐
Lungs	Shortness of Breath at rest	44.	☐	☐
	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	45.	☐	☐
	Shortness of breath when walking with other people at an ordinary pace on level ground	46.	☐	☐
	Have to stop for breath when walking at your own pace on level ground	47	☐	☐
	Shortness of breath when washing or dressing yourself	48.	☐	☐
	Shortness of breath that interferes with your job	49.	☐	☐

			Yes	No
	Coughing that produces phlegm (thick sputum)	50	☐	☐
	Coughing that wakes you early in the morning	51	☐	☐
	Coughing that occurs mostly when you are lying down	52	☐	☐
	Coughing up blood in the last month	53	☐	☐
	Wheezing	54.	☐	☐
	Wheezing that interferes with your job	55	☐	☐
	Chest pain when you breathe deeply	56	☐	☐
	Any other symptoms that you think may be related to lung problems	57.	☐	☐
Respirator	Skin problems with respirator use	58.	☐	☐
	Anxiety with respirator use	59.	☐	☐
	Musculoskeletal problem that interferes with respirator use	60.	☐	☐
	Any other problems that interfere with your use of a respirator	61.	☐	☐
Heart	Chest Pain or tightness at rest	62.	☐	☐
	Chest pain or tightness with exertion	63.	☐	☐
	Pain or tightness in your chest that interferes with your job	64.	☐	☐
	In the past two years, have you noticed your heart skipping or missing a beat	65.	☐	☐
	Heartburn or indigestion that is not related to eating	66..	☐	☐
	Heart murmur	67.	☐	☐
Breast	Lumps	68.	☐	☐
	Discharge	69.	☐	☐
Abdomen	Nausea/vomiting	70.	☐	☐
	Change in bowel habits	71.	☐	☐
	Bloody stools	72.	☐	☐
	Black tarry stools	73..	☐	☐
	Heartburn	74.	☐	☐
	Ulcer disease	75.	☐	☐
	Diarrhea	76.	☐	☐
	Constipation	77.	☐	☐
	History of jaundice	78.	☐	☐
	Abdominal pain	79.	☐	☐
	Hernia	80..	☐	☐
	Food intolerance	81.	☐	☐
Genito-urinary	Increased frequency of urination	82.	☐	☐
	Burning with urination	83.	☐	☐
	Blood in urine	84.	☐	☐

			Yes	No
	Kidney Stones		☐	☐
	Infections in urine		☐	☐
Spine	Difficulty moving arms or legs	87.	☐	☐
	Difficulty moving head up or down	88.	☐	☐
	Difficulty moving head side to side	89.	☐	☐
	Weakness in any extremity	90	☐	☐
	Back Pain	91	☐	☐
	Back Injury	92.	☐	☐
	Back Surgery	93.	☐	☐
Joints	Swelling	94.	☐	☐
	Stiffness	95	☐	☐
	Pain on motion	96	☐	☐
	Loss of motion	97	☐	☐
	Difficulty bending at knees	98.	☐	☐
	Difficulty squatting	99.	☐	☐
Vascular	Circulation problems	100	☐	☐
	Leg Cramps	101	☐	☐
	Varicose Veins	102	☐	☐
	Phlebitis	103	☐	☐
Neurologic	Seizures	104	☐	☐
	Headaches	105	☐	☐
	Fainting	106	☐	☐
	Numbness	107	☐	☐
	Weakness	108	☐	☐
	Dizziness	109	☐	☐
	Trouble Speaking	110	☐	☐
	Tremors	111	☐	☐
Women Only	Latest menstrual period date	112	☐	☐
	# Pregnancies	113		
	# Miscarriages	114		
	# Births	115		
Men Only	Infertility	116.	☐	☐
	Prostate problems	117.	☐	☐

Do you believe you have a current disability that you feel needs accommodation? ☐ Yes ☐ No
If yes, what is the disability and what is the accommodation requested? _____

_____

_____

Comments and/or Explanations:

_____

_____

_____

Examiner Comments:

_____

_____

_____

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