CASE WESTERN RESERVE UNIVERSITY EST. 1826

University Health Service
Division of Student Affairs

10900 Euclid Avenue
Cleveland, Ohio 44106-4901

Phone 216.368.2450
Fax 216.368.8530
healthservice@case.edu

students.case.edu/health

Health Service Occupational Health Medical History

Employee Information

Name ______________________________
Last First Middle/Maiden

Home Address ______________________________
Street City Zip Code

Home Telephone # ____________ Date of Birth ____________ (MM/DD/YYYY) ○ Male ○ Female

Position ____________ Department ____________ Supervisor ____________

Campus Telephone # ____________ Email Address ____________

In Emergency Notify ____________ Telephone # ____________

Address ______________________________

Have you ever worked at Case Western Reserve University? ○ Yes ○ No

Has your name changed? ○ Yes ○ No Please give previous name ____________

Medical History

Current physicians or clinics attended:

Name ______________________________

Address ______________________________

Allergy History:

Medicine/Drugs ______________________________

Foods, Insects, etc. ______________________________

Medication/Drugs taken regularly______________________________

Have you had or do you now have? (Please check all that apply)

- ☐ Seizures
- ☐ Bone or joint pain
- ☐ High blood pressure
- ☐ Loss of eye sight
- ☐ Bleeding problems
- ☐ Breathing problems
- ☐ Parkinson's disease
- ☐ Heart disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Amputation
- ☐ Tuberculosis
- ☐ Multiple sclerosis
- ☐ Muscular dystrophies
- ☐ Backache (chronic)
- ☐ Black out spells
- ☐ Blood clots
- ☐ Neurological problems
- ☐ Disability/Rehabilitation
- ☐ Diabetes
- ☐ Varicose veins
- ☐ Stroke
- ☐ Circulation problems
- ☐ Immune system disease
- ☐ Hepatitis/Jaundice

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Please list any other medical problems you may have: ______________________

Have you had any of the following: ______________________

Hernia Repair Type: ______________ Date: ______________

Orthopedic Surgery Type: ______________ Date: ______________

Cardiac Surgery Type: ______________ Date: ______________

Other Surgery Type: ______________ Date: ______________

Date of Immunization:

Tetanus booster: ______________________

Rubella Immunization: ______________________

Measles Immunization: ______________________

Rabies Immunization: ______________________

Rabies Titer: ______________________

Have you had Hepatitis B vaccine? ○ Yes ○ No Approximate Date: ______________

Do you smoke? ○ Yes ○ No If yes, what? ______________________

Do you exercise? ○ Yes ○ No

If yes, How frequently? __________ For what length of time? __________

Have you had any serious accidents or illnesses not noted? ○ Yes ○ No

Explain: ______________________

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Prior Work Environment

Have you ever had an On the Job injury? ○ Yes ○ No

If Yes, Date ____________________ Place ____________________

Explain ______________________________

Have you ever worked with:

Carcinogens? ○ Yes ○ No

Asbestos? ○ Yes ○ No

Radio-active materials? ○ Yes ○ No

Radiation producing equipment? ○ Yes ○ No

If 'YES" please indicate where ______________________________

Do you understand all of these questions? ○ Yes ○ No

Case Work Environment

What are your duties? ______________________________

Will you be:

Doing any lifting? ○ Yes ○ No

Working with chemicals? ○ Yes ○ No

What kind? ______________________________

Working with patients? ○ Yes ○ No

Where? ______________________________

Handling experimental animals? ○ Yes ○ No

What kind? ______________________________

Working with radiation? ○ Yes ○ No

Picking up biohazard waste for disposal? ○ Yes ○ No

I have completed this form and I certify that the information given is true.

____

Signature Date