General Medical Questionnaire

Answer all questions as accurately as possible.

Today's Date (mm/dd/yy): ____/____/_____ Date of Birth (mm/dd/yy): ____/____/____

Name (Last, First, Middle Initial): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Employee ID #: _____Last Four Digits of SSN: _____Job Title:_____

Directions

- Applicant/Employee— Please sign and complete this questionnaire and print your name on each page.

I certify that my answers are true and correct. I have reviewed and signed a separate Medical Release that authorizes the designated medical practitioner who completed this medical evaluation, to disclose my health information to AllOne Health Resources.

Applicant/Employee Signature:_____ Date:_____
MM/DD/YY

I certify that I have reviewed this medical questionnaire.

Medical Practitioner Signature:_____ Date:_____
MM/DD/YY

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.

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Personal History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Gender ☐ Male ☐ Female	# of children:	Country where you were born:

Do you smoke tobacco? ☐ Yes ☐ No	# of packs smoked per day:	Did you smoke in the past? ☐ Yes ☐ No	# Years:	Quit Date: ____/____/____
Do you use smokeless tobacco? ☐ Yes ☐ No	Amount used per day:	Have you used smokeless tobacco in the past? ☐ Yes ☐ No	# Years:	Quit Date: ____/____/____

Do you exercise? ☐ Yes ☐ No	If yes, how often do you exercise (times per week)?	What types of exercise do you do?

Do you ever drink alcoholic beverages? ☐ Yes ☐ No	If yes, how often?	When was your last drink? ____/____/____

Have you ever had a drug or alcohol problem? ☐ Yes ☐ No	If yes, please explain:

Are you: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Occupational History

What was your prior occupation?		Describe work activities in prior occupation:
Number of years at prior occupation:	Have you ever been injured at work? ☐ Yes ☐ No	If yes, give date and describe:

Have you served in the military? ☐ Yes ☐ No	Have you traveled internationally in the previous year? ☐ Yes ☐ No	If yes, list the countries: _____ _____

Are you currently considered disabled? ☐ Yes ☐ No If yes, type of disability: _____	Are you currently receiving disability benefits? ☐ Yes ☐ No If yes: ☐ SSDI ☐ Veteran ☐ W/C ☐ Other _____

Please list any medications you are currently taking:

Drug	Dose/Time	Drug	Dose/Time
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Please list any medication ALLERGIES or environmental ALLERGIES:

1.
2.
3.
4.

Have you ever had any of the following? Check all appropriate boxes:

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

Please list any hospitalizations or operations.

Hospitalization/Operation	Complications	Year	Hospital
1.			
2.			
3.			
4.			

Please list any accidents or injuries (e.g., broken bones/fractures, sprains, strains, including joint cartilage or ligament injuries) and associated dates.

Description	Date(s)
1.	
2.	
3.	
4.	

Additional Comments and/or Explanations:

_____

_____

Examiner Comments:_____

_____

MEDICAL HISTORY AND PHYSICAL EXAM

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

			Yes	No				Yes	No
General	Anemia	1	☐	☐	Lungs	Cough	41	☐	☐
	Fevers	2	☐	☐		Sputum	42	☐	☐
	Recent loss/gain in past 6 months	3	☐	☐		Cough up blood	43	☐	☐
	Chills or fever	4	☐	☐		Shortness of breath	44	☐	☐
	Night sweats	5	☐	☐		Wheezing	45	☐	☐
	Swollen glands	6	☐	☐		Pneumonia	46	☐	☐
	Swelling in your groin or armpit	7	☐	☐		Bronchitis	47	☐	☐
	Fatigue	8	☐	☐		Emphysema	48	☐	☐
	Allergies	9	☐	☐		Chest Pain	49	☐	☐
Skin	Rashes	10	☐	☐		Shortness of breath	50	☐	☐
	Poor healing	11	☐	☐		on exertion	A	☐	☐
	Easy bruising	12	☐	☐		at rest	B	☐	☐
	Change in lumps/moles	13	☐	☐	Heart	Palpitations	51	☐	☐
Eyes	Blurring	14	☐	☐		Ankle swelling	52	☐	☐
	Double vision	15	☐	☐		Rheumatic fever	53	☐	☐
	Pain	16	☐	☐		Heart murmur	54	☐	☐
	Cataracts	17	☐	☐		Irregular heart beat	55	☐	☐
	Glaucoma	18	☐	☐	Breasts	Lumps	56	☐	☐
	Wear glasses/contacts	19	☐	☐		Discharge	57	☐	☐
	Date of last eye exam:	20	☐	☐		Mammography	58	☐	☐
Ears	Wear hearing aid	21	☐	☐	Abdomen	Nausea/vomiting	59	☐	☐
	Ringing	22	☐	☐		Change in bowel habits	60	☐	☐
	Deafness/trouble hearing	23	☐	☐		Bloody stools	61	☐	☐
	Infections	24	☐	☐		Black tarry stools	62	☐	☐
Nose, Sinus	Infections	25	☐	☐		Heartburn	63	☐	☐
	Bleeding	26	☐	☐		Ulcer disease	64	☐	☐
	Nasal congestion without a cold	27	☐	☐		Diarrhea	65	☐	☐
Throat	Infections/strep	28	☐	☐		Constipation	66	☐	☐
	Hoarseness	29	☐	☐		History of jaundice	67	☐	☐
	Trouble Swallowing	30	☐	☐		Abdominal pain	68	☐	☐
Endocrine	Thyroid problems	31	☐	☐		Hernia	69	☐	☐
	Cold intolerance	32	☐	☐		Food intolerance	70	☐	☐
	Heat intolerance	33	☐	☐	Genito-urinary	Urgency	71	☐	☐
	Excessive thirst	34	☐	☐		Increased frequency	72	☐	☐
	Excessive hunger	35	☐	☐		Bleeding	74	☐	☐
	X-ray treatment to head, neck	36	☐	☐		Kidney stones	75	☐	☐
Oral	Seen by dentist within last year	37	☐	☐		Infections	76	☐	☐
	Gums bleed easily	38	☐	☐					
	Teeth	39	☐	☐					
	Sense of taste	40	☐	☐					

MEDICAL HISTORY AND PHYSICAL EXAM

REVIEW OF SYSTEMS (continued) Do you have an existing and/or recent problem with:

			Yes	No
Bones/ Joints	Back pain injury/surgery	77	☐	☐
	Pain	78	☐	☐
	Stiffness	79	☐	☐
	Swelling	80	☐	☐
	Tenderness	81	☐	☐
	Pain on motion	82	☐	☐
	Limited motion	83	☐	☐
Vascular	Circulation problems	84	☐	☐
	Leg cramps	85	☐	☐
	Varicose veins	86	☐	☐
	Phlebitis	87	☐	☐
Nerves	Seizures	88	☐	☐
	Fainting	90	☐	☐
	Numbness	91	☐	☐
	Weakness	92	☐	☐
	Anxiety	96	☐	☐
	Depression	97	☐	☐
	Difficulty sleeping	98	☐	☐
	Headaches	99	☐	☐
Women Only	Latest menstrual period Date	100		
Men Only	Prostate Problems	101	☐	☐

Mark as many as apply:

1. **Within the past 6 months have you had a problem with:**
   ☐ **appetite** ☐ **falling asleep** ☐ **staying asleep** ☐ **trembling** ☐ **tension** ☐ **relaxing**
   ☐ **stress** ☐ **none**

2. **During the past year have emotional problems affected your work or personal life enough to require treatment?**
   ☐ **Yes** ☐ **No**

   If yes, explain _____

Comments and/or Explanation of Positive or Abnormal Responses: _____

_____

_____