The Smarter Choice for Care
Middlesex Health
Occupational + Environmental Medicine

534 Saybrook Road
Middletown, CT 06457
P: 860-358-2750
F: 860-358-2757

252 Westbrook Road
Essex, CT 06426
P: 860-358-3840
F: 860-358-3843

COMPREHENSIVE HISTORY/PHYSICAL EXAM FORM

PERSONAL DATA **DATE:** _____

Patient Name:_____ Date of Birth:_____ Sex: ☐ M ☐ F
Address:_____ City:_____ State:_____ Zip:_____ Home phone:_____
Place of Birth:_____ Company:_____ Position applied for:_____
Employed previously by this Co. ☐ Yes ☐ No If Yes, indicate when _____
Whom do we notify in case of an emergency? (Name/Relationship)_____ Phone #:_____
Primary Care Physician:_____ City/State:_____
Information requested herein will not be used in any manner contrary to any law, rule or regulation and is obtained only for medical examination to ensure safe job placement in consideration of specific job demands and exposures.

A. MEDICAL HISTORY Have you ever had or have any of the following illnesses? (Yes or No)

	Yes	No		Yes	No
Chest Pain / Pressure	☐	☐	Hernia	☐	☐
Heart Disease	☐	☐	Swollen Legs	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐
Stroke	☐	☐	Thyroid Problems	☐	☐
Lung Disease/Asthma/ COPD	☐	☐	Arthritis / Rheumatism	☐	☐
Tuberculosis	☐	☐	Glaucoma / Cataracts	☐	☐
Sleep Apnea	☐	☐	Hearing Problems/ Perforated Ear Drums	☐	☐
Chronic Cough	☐	☐	Skin Problems	☐	☐
Dizziness / Fainting	☐	☐	Liver Disease	☐	☐
Backache / Pain	☐	☐	Cancer	☐	☐
Epilepsy (seizures)	☐	☐	Allergies	☐	☐
Kidney Problems/Blood in Urine	☐	☐	Anemia	☐	☐
Frequent Headache	☐	☐	Stomach or Bowel Problems including Ulcers	☐	☐

Please explain above Yes responses: _____

Have you ever been treated for…?	Yes	No	Explain for all Yes responses:
Drug Addiction or Alcoholism	☐	☐	
Depression	☐	☐	
Have you ever smoked?	☐	☐	
Do you drink alcoholic beverages?	☐	☐	
Have you ever had or been advised to have surgery?	☐	☐	
Are you allergic to any medication?	☐	☐	
Are you taking any medications presently?	☐	☐	
Have you had a recent medical examination?	☐	☐	

B.) INJURIES

Have you ever experienced:	Yes	No		Yes	No
Bone Fracture	☐	☐	Upper Extremities (Shoulder/Arm/Wrist/Hand) Injuries	☐	☐
Back Injuries	☐	☐	Lower Extremities (Leg/Knee/Foot) Injuries	☐	☐
Head Injuries	☐	☐	Lost Consciousness	☐	☐
Neck Injuries	☐	☐	Car Accident with Injury	☐	☐

Comments:_____

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PATIENT NAME: _____ DOB: _____

C. OCCUPATIONAL PROFILE

Back History:	Yes	No	Explain:
1)Have you ever experienced back injury that resulted in:			
Lost time from work/school	☐	☐	
Visit to the doctor	☐	☐	
Visit to the chiropractor or physical therapy	☐	☐	
2)Have you ever had:			
Back x-rays , CT Scan or MRI	☐	☐	

Have you ever been or are you now exposed to any of the following? Have you ever been treated for any of the following?

	Exposed		Treated			Exposed		Treated			Exposed		Treated	
	Yes	No	Yes	No		Yes	No	Yes	No		Yes	No	Yes	No
Metals	☐	☐	☐	☐	Extreme Heat / Cold	☐	☐	☐	☐	Loud Noise	☐	☐	☐	☐
Fumes	☐	☐	☐	☐	Chemicals	☐	☐	☐	☐	Radiation	☐	☐	☐	☐
Vibration	☐	☐	☐	☐	Biologic Agents	☐	☐	☐	☐	Blood/Bodily Fluids	☐	☐	☐	☐
										Dust or Fibers	☐	☐	☐	☐

Comments: _____

Fill in table below listing all jobs you have worked including short-term, seasonal, part-time employment and military service. Begin with your **most recent job**.

Dates of Employment	Job Title / Description of work / Employer	Exposures (chemicals, blood, etc…)

Have you ever received Disability or Compensation Benefits? ☐Yes ☐No If yes, indicate where and when:

_____

Have you ever lost time at work due to an injury or illness? ☐Yes ☐No If yes, explain:

_____

Have you ever been advised to change jobs or work assignments because of any health problems or injuries? ☐Yes ☐No If yes, explain: _____

_____

Immunization History:	Date(s):		Date(s):
Varicella/Chicken Pox		Hepatitis B	
Measles/Mumps/Rubella/(MMR)		Hepatitis A	
Tetanus (dT, Tt)		Influenza	
Polio		Pneumovax	

List any problems that you wish to discuss with the doctor: _____

_____

_____

D: MEDICAL DECLARATION

I CERTIFY THAT THE FOREGOING IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE I UNDERSTAND THAT I MAY BE REQUESTED AT THE OPTION OF MY EMPLOYER TO COMPLETE A PHYSICAL EXAMINATION I AUTHORIZE ANY OF THE DOCTORS, CLINICS OR HOSPITALS MENTIONED ABOVE TO FURNISH A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSE OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT, SUBJECT TO CONFIDENTIALITY STATUTES

Date: _____ **Signature:** _____