



MEDICAL HISTORY QUESTIONNAIRE

The information you provide is personal and confidential.

- ✓ Do not return completed questionnaire to the Department of Environmental Health & Safety. Take completed form with you to your scheduled appointment with the Medical Provider. Your medical records will remain on file with the Medical Provider.
- ✓ To schedule appointment with the Medical Provider, please refer to the "Medical Surveillance Appointment Procedure". www.fiu.edu/~ehs/med_surv/appt.pdf

Name: _____	Date: _____
Panther ID: _____	What is your position? (or position you are applying for?) _____
Date of Birth: _____	Job/Position: _____
Address _____	Department: _____
City/State/Zip Code _____	Department Supervisor/Manager (if known) _____
Home Phone (_____) _____	Work Phone: (_____) _____
Email: _____	
Brief Job Description: 	

Employment History: Start with the job you held before this one, and list **all** the jobs you ever had. Include military service and any part-time jobs.

Company name	From Month/Year	To Month/Year	Job Title/Description

RECREATIONAL HISTORY

Do you now or have you in the past, done any of the following as a hobby or during your spare time?	No	Previously	Currently
Auto mechanic work			
Auto body work			
Been exposed to rubber cement for extended periods of time			
Carpentry			
Ceramics			
Etching/metal work/jewelry/metal sculpture			
Furniture refinishing			
House painting			
Lawn/Garden maintenance or farming			
Oil painting			
Acids			
Bonding agents or industrial glues			
Cleaning fluids			
Fertilizers			
Gasoline or other petroleum products			
Herbicides or weed killers			
Insecticides/pesticides			
Insulation material			
Lacquer, varnish or enamel paints			
Leather dyes			
Paint thinners and removers			
Soldering agents			
Solvents/degreasers			
Wood stains			

In your work are you now or have you been exposed to any of the following agents?

	Present	Past		Present	Past
Inorganic fluorides			Nitrogen oxides		
Lead			Crystalline silica		
Benzene			Nitric acid		
Coke oven emissions			Ammonia		
Inorganic arsenic			Beryllium		
Methylene chloride			Phosgene		
Vinyl chloride			Allyl chloride		
Toluene diisocyanate			Asbestos		
Excessive noise			Suspect or known carcinogens		
Pesticides			Bacteria or viruses		
Primate animals			Vibrating tools		
Radiation (<i>Ionizing</i>)			Radiation (<i>Non-Ionizing</i>)		

Please make a list of those substances that you handle in your work. Place an asterisk beside any that particularly concern you from a health standpoint.

Indicate any symptoms that you have experienced that might be due to exposure at work and indicate the suspected cause.

Symptom	Suspected Cause

Have you experienced any **job related** illnesses or injuries since being employed by FIU?

No Yes If Yes, Month and Year: _____

If yes, please give details: _____

SMOKING HISTORY

CIGARETTES: Have you ever smoked cigarettes regularly? No Yes

(‘No’ means never smoked or smoked less than 20 packs of cigarettes or 12 ozs. of tobacco in life time or less than one cigarette a day for one year.)

If ‘yes’ please answer the following questions: -

- a. How old were you when you started smoking cigarettes regularly? _____ Years.
- b. Do you still smoke cigarettes? Yes No If yes, how many cigarettes do you now smoke per day? _____ Cig/day.
- c. If you have stopped smoking cigarettes, how old were you when you stopped? ____ Years
- d. On the average, of the entire time you have smoked, how many cigarettes did you smoke per day? _____ Cig/day.
- e. Do, or did you inhale the cigarette smoke? Yes No.

PIPES: Have you ever smoked a pipe regularly? Yes No
(*"No" means never smoked, or smoked no more than 12 ozs. of pipe tobacco in your lifetime.*)

If 'yes' please answer the following questions: -

- a. How old were you when you started smoking pipes regularly? _____ Years.
- b. Do you still smoke pipes? If yes, how many ounces of pipe tobacco do you now smoke per week? No Yes _____ Ozs. / Week.
- c. If you have stopped smoking a pipe, how old were you when you stopped? _____ Years
- d. On the average, of the entire time you have smoked, how many ounces of tobacco did you smoke per day? _____ Ozs. / Week.
- e. Do, or did you inhale the pipe smoke? No Yes.

CIGARS: Have you ever smoked cigars regularly? No Yes
(*"No" means never smoked, or smoked no more than 1 cigar a week for 1 entire year.*)

If 'yes' please answer the following questions: -

- a. a. How old were you when you started smoking cigars regularly? _____ Years
- b. Do you still smoke cigars? If yes, how many cigars do you now smoke per day?
 No Yes _____ Cigars/Day
- c. If you have stopped smoking cigars, how old were you when you stopped? _____ Years
- d. On the average, of the entire time you have smoked cigars, how many cigars did you smoke per day? _____ Cigars/Day
- e. Do, or did you inhale the cigar smoke? No Yes

TOBACCO CHEWING: Have you ever-chewed tobacco regularly? No Yes

If 'yes' please answer the following questions: -

- a. How old were you when you started chewing tobacco regularly? _____ Years.
- b. Do you still chew tobacco? No Yes
- c. If you have stopped chewing tobacco, how old were you when you stopped? _____ Years

SNUFF: Have you ever used snuff regularly? No Yes

If 'yes' please answer the following questions: -

- a. How old were you when you started using snuff regularly? _____ Years
- b. Do you still use snuff? No Yes
- c. If you have stopped using snuff, how old were you when you stopped? _____ Years

LIFE-STYLE HISTORY

ALCOHOLIC BEVERAGES: Do you now or have you ever drunk alcoholic beverages (such as wine, beer, or hard liquor) regularly? No Yes

If 'yes' please answer the following questions: -

- a. Which of the following do you regularly drink? *(Check all that apply.)*
 Wine Beer Liquor.
- b. Have you stopped drinking regularly? No Yes
If yes, how many years ago did you stop? _____ Years
- c. How much do (did) you drink on an average day or in an average week?
 Less than 1 drink per day, or less than 7 drinks per week.
 1 to 2 drinks per day, or 7 to 17 drinks per week.
 3 to 4 drinks per day, or 18 to 31 drinks per week.
 5 or more drinks per day, or more than 31 drinks per week.

EXERCISE: Do you get exercise on a regular basis? No Yes

If 'yes' please answer the following questions: -

- a. How many days per week? _____ Days/Week.
- b. How many minutes do you exercise? _____ Minutes
- c. Describe the kind of exercise you get: _____

DIET:

- a. Do you drink more than two cups of coffee or tea a day? No Yes.
- b. Do you restrict your diet? No Yes
(If yes, which of the following items do you restrict?)
 Meat Sodium or Salt Sugar foods high in cholesterol
 Other (describe): _____

- c. How many years have you been restricting your diet? _____ Years
- d. Why are you restricting your diet?
 Religious Reasons
 Medical Reasons
 Others (describe): _____

MEDICAL HISTORY

CARDIOVASCULAR: <i>Have you ever had or do you now have any of the following illnesses or problems with your heart or blood vessels?</i>	No	Yes Past	Yes Current
Heart Attack			
Angina Pectoris			
Heart Murmur			
Enlarged Heart			
Stroke			
High Blood Pressure			
Other problems with blood pressure			
Episodes of chest pains, tightness, discomfort			
Rheumatic Heart Disease			
Arteriosclerosis			
Varicose Veins			
Have you ever had heart surgery? , If yes please specify:			
Other (<i>specify</i>):			

DIGESTIVE SYSTEM: <i>Have you ever had or do you now have any of the following illnesses or problems with your digestive system?</i>	No	Yes Past	Yes Current
Blood in stool			
Stomach or Duodenal Ulcer			
Appendicitis			
Nervous stomach			
Colitis			
Frequent constipation			
Other problems with blood pressure			
Frequent diarrhea			
Frequent indigestion			
Stomach pain			
Hiatal hernia or rupture			
Diverticulitis			
Hemorrhoids or piles			
Other (<i>specify</i>):			

RESPIRATORY ILLNESS/CONDITIONS: <i>Have you had or do you now have any of the following illnesses or problems with your lungs?</i>	No	Yes Past	Yes Current
Frequent Colds			
Coughed up Blood			
Chronic Cough			

RESPIRATORY ILLNESS/CONDITIONS: <i>Have you had or do you now have any of the following illnesses or problems with your lungs?</i>	No	Yes Past	Yes Current
Lung or Breathing difficulties or Shortness of Breath			
Asthma			
Emphysema			
Pneumonia			
Tuberculosis			
Bronchitis			
Pleurisy			
Have you ever had surgery on your lungs? (If yes, describe):			
Other (specify):			

ENT: <i>Have you ever had or do you now have any of the following problems with your mouth, nose or throat?</i>	No	Yes Past	Yes Current
Nasal passages frequently irritated			
Nose Bleeds often			
Throat is often irritated			
Voice is hoarse when you do not have a cold			
Mouth/Gums frequently have sores/ulcers			
Gums shrinking, irritated or bleeding			
Other (specify):			

LIVER AND SPLEEN: <i>Have you ever or do you now have any of the following illnesses or problems with your liver, spleen, or gallbladder?</i>	No	Yes Past	Yes Current
Cirrhosis of the liver			
Hepatitis			
Jaundice			
Gallbladder disease			
Gallbladder stones			
Injury to your spleen			
Have you ever had surgery on your liver or spleen? (If yes, describe):			
Other (specify):			

ENDOCRINE: <i>Have you ever had or do you now have any of the following illnesses or conditions?</i>	No	Yes Past	Yes Current
Hypoglycemia			
Diabetes			
Goiter			
Thyroid disease or disorder			
Swollen glands or nodes			
Pancreatitis			
Other gland problems (<i>specify</i>):			

KIDNEYS/URINARY TRACT: <i>Have you ever had or do you now have any of the following illnesses or problems with your kidneys or urinary tract?</i>	No	Yes Past	Yes Current
Blood in urine			
Pain or burning when urinating			
Kidney disease			
Kidney infection			
Kidney stones			
Nephritis (<i>Bright's Disease</i>)			
Bladder Infection			
Prostate gland enlargement/infection (<i>Males only</i>)			
Tumor in urinary tract			
Have you ever had surgery on your kidneys or urinary tract? (<i>If yes, describe</i>):			
Other (<i>specify</i>):			

REPRODUCTIVE HISTORY (*please answer all four questions*):

- Have you or your partner ever had a problem conceiving a child? No Yes
If yes, Self Present Partner Previous Partner
- Have you or your partner consulted a physician for fertility or other reproductive problem? Yes No
If yes, specify who consulted the physician: Self Partner Self and Partner
If yes, specify the diagnosis: _____

- Have you or your partner ever conceived a child resulting in a miscarriage, still-birth?
 No Yes If yes, Miscarriage Still Birth Deformed Offspring.
If outcome was a deformed offspring, what was the deformity? _____

- Was this outcome a result of a pregnancy with your: Present partner Prior Partner
- Did the timing of any abnormal pregnancy outcome coincide with your present employment? Yes No

NERVOUS SYSTEM: <i>Have you ever had or do you now have any of the following illnesses or problems with your nervous system?</i>	No	Yes Past	Yes Current
Frequent headaches			
Migraine headaches			
Epilepsy, convulsions, seizures			
Nervous breakdown			
Depression/Excessive worry			
Loss of memory (<i>amnesia</i>)			
Nervousness			
Tremor of the hands or head			
Palsey or tremors			
Severe head injury			
Neuritis			
Paralysis of any type			
Other problems (<i>specify</i>):			

BLOOD: <i>Have you ever had or do you now have any of the following blood diseases or problems?</i>	No	Yes Past	Yes Current
Anemia			
Low hemoglobin			
Bleeding disorder			
Leukemia			
Sickle cell disease or trait			
Phlebitis			
Have you ever had a blood transfusion?			
Other problems (<i>specify</i>):			

ALLERGIES: <i>Have you ever had or do you now have any allergies to the following:</i>	No	Yes Past	Yes Current
Medications (<i>If yes, please list</i>):			
Any food items (<i>If yes, please list</i>):			
Soaps or detergents			
Chromium			
Nickel			
Rubber			
Epoxy resins			
Plants (e.g., poison ivy, etc.)			
Pollen			
Insect scales			

ALLERGIES: <i>Have you ever had or do you now have any allergies to the following:</i>	No	Yes Past	Yes Current
House dust			
Animal dander, feathers, or fur			
Sunlight or cold			
Other (If yes, please list):			
Do you react with:			
Rash			
Hives			
Hay fever symptoms			
Breathing difficulty			
Other (If yes, describe):			

BONES AND JOINTS: <i>Have you ever had or do you now have any of the following problems with your bones or joints?</i>	No	Yes Past	Yes Current
Arthritis or Rheumatism			
Gout			
Joint pains			
Bone infections			
Bursitis or tendonitis			
Backache, back trouble, sciatica			
Foot trouble, flat feet or fallen arches			
"Trick", "locked", or "loose" knee			
Back injury or herniated disk			
Painful or trick shoulder			
Swollen or painful joints			
Have you ever had surgery (<i>including setting of broken bones</i>) on any of your bones or joints? (<i>If yes, describe</i>):			
Other problems with your bones or joints (<i>If yes, Please specify</i>):			

SKIN: <i>Have you ever had or do you now have any of the following skin disorders?</i>	No	Yes Past	Yes Current
Hives			
Eczema			
Psoriasis			
Rash on elbows, knees, or scalp			
Rash other than on elbows, knees, or scalp			
Severe stubborn dandruff			
Small itching blisters on the sides of your fingers or palms			
Excessive sweating on palms, soles, or armpits			
Sores that do not heal			
Moles that bleed or get larger			

SKIN: <i>Have you ever had or do you now have any of the following skin disorders?</i>	No	Yes Past	Yes Current
Change in color of skin (<i>other than suntan</i>)			
New growth on skin			
Other (<i>If yes, describe</i>):			

EARS: <i>Have you ever had or do you now have any of the following problems with your ears or your hearing?</i>	No	Yes Past	Yes Current
Difficulty in hearing			
Tinnitus (<i>ringing/buzzing</i>) in right ear			
Tinnitus (<i>ringing/buzzing</i>) in Left ear			
Nasal allergy			
Vertigo (<i>dizziness</i>)			
Perforation of the ear drum			
Ear drainage (<i>caused by infection or injury</i>)			
High fever			
Infection of inner ear			
Hearing loss by blood relatives (<i>such as grandparents, parents, aunts, uncles, brothers, or sisters</i>) before they reached the age of 60			
Other problems with your ears (<i>If yes, describe</i>):			

EYES: <i>Have you ever had or do you now have any of the following problems with your eyes or your vision?</i>	No	Yes Past	Yes Current
Glaucoma			
Cataracts			
Conjunctivitis			
Blurring of eyesight			
Vision getting worse			
Seeing double			
Seeing halos around lights			
Pain in the eyeball			
Eyes are often bloodshot			
Left eye Injured (<i>e.g., scratched, burned, cut, etc.</i>)			
Right eye Injured (<i>e.g., scratched, burned, cut, etc.</i>)			
Left eye -Foreign object accidentally embedded in the eye			
Right eye -Foreign object accidentally embedded in the eye			
Do you wear glasses?			
Do you wear contact lenses?			
Other problems with your eyes (<i>If yes, describe</i>):			

CANCER: Have you ever been diagnosed with cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list the year and type of diagnosis.)		
Type	Year	Specific Tissue Diagnosis (If available)
Skin		
Colon		
Breast		
Lung		
Prostate		
Cervical		
Other (If yes, specify type and describe tissue diagnosis and year):		

INFECTIOUS/CHILDHOOD DISEASES: Have you had or do you now have:	No	Yes Past	Yes Current
Mononucleosis			
Meningitis			
Malaria			
Polio			
Rheumatic fever			
Scarlet fever			
Mumps			
Measles			
Chicken pox			
German measles			
Tonsillitis			
Gonorrhea			
Syphilis			

FAMILY HISTORY: Have any of your blood relatives (parents, grandparents, brothers, sisters, aunts, uncles or children) had any of the following illnesses or conditions?	No	Yes Past	Yes Current
Anemia			
Alcoholism			
Allergies			
Arthritis			
Asthma			
Bleeding disorders (free bleeder)			
Breast cancer			
Cervical cancer			
Chronic bronchitis			
Congenital malformations (birth defect)			
Diabetes (sugar)			
Digestive or bowel disease			
Eczema			
Emphysema			
Epilepsy			

FAMILY HISTORY: <i>Have any of your blood relatives (parents, grandparents, brothers, sisters, aunts, uncles or children) had any of the following illnesses or conditions?</i>	No	Yes Past	Yes Current
Glaucoma			
Gout			
Hay fever			
Heart attack			
Heart disease			
High blood pressure			
Kidney or bladder disease			
Kidney stones			
Liver or gallbladder disease			
Lung cancer			
Mental illness			
Mental retardation			
Nervous system disease			
Psoriasis			
Sickle cell disease or trait			
Stroke			
Thyroid disease			
Tuberculosis (<i>T.B.</i>)			
Ulcer (<i>stomach, duodenal, peptic</i>)			
Other cancers or leukemia			
Are you aware of any other disease or illnesses that run in your family? (<i>If yes, please list below</i>): <input type="checkbox"/> No <input type="checkbox"/> Yes			

MEDICATIONS: <i>Have you taken any of the following medications?</i>	No	Yes Past	Yes Current
Antacids			
Antibiotics (<i>e.g., penicillin, ampicillin, tetracycline</i>)			
Antihistamines			
Aspirin			
Benzedrine / Dexedrine			
Birth control pills			
Blood thinners (<i>anti-coagulants</i>)			
Codeine			
Cortisone or other steroids			
Diet pills			
Digitalis or other heart pills			
Diuretic or water pills			
Hormones			
Insulin or oral anti-diabetic drugs			
Iron pills			
Laxatives			
Morphine			

MEDICATIONS: <i>Have you taken any of the following medications?</i>	No	Yes Past	Yes Current
Nitroglycerine			
Pain killers (<i>aspirin, empirin, anacin, bufferin, etc.</i>)			
Pep pills or Mood elevators			
Pills to lower your blood pressure			
Sleeping pills			
Sulfa preparations			
Thyroid medication			
Tranquilizers, sedatives, or nerve pills			
Vitamins			
Others			

IMMUNIZATIONS, VACCINES, ANTITOXINS: <i>If you have received any of the following: (give the approximate dates, if known).</i>	No	Yes	Date
Tetanus			
Poliomelitis			
Influenza			
Typhoid			
Diphtheria			
Rabies			
Rubella (German measles)			
Measles (Rubeola or red measles)			
BCG			
Yellow Fever			
Smallpox			
RhoGAM (<i>Rh immune globulin</i>)			
Mantoux, patch test, or other skin test for tuberculosis If Yes, <input type="checkbox"/> Positive <input type="checkbox"/> Negative			
Other: (Please list)			

History of Hospitalization: Have you ever been hospitalized? No Yes
(If yes, list reason(s) and date(s) of hospitalization.)

Reasons	Dates

Do you have any problems you would like to discuss with the doctor? No Yes
(If yes, please list them):

Signature: _____

Date Completed: _____