



Occupational Health Services
Health History

Date: _____
Name: _____ D.O.B. _____ Cell Phone # _____
Home Address: _____ Email Address: _____
Current Health Care Provider: _____
Address: _____ Phone Number: _____

Family Health:

Current state of health: alive or deceased, and current health conditions.

Mother: _____
Father: _____

Allergies:

No Yes If yes, describe reaction:

- Food _____
- Drug _____
- Environmental _____
- Latex _____
- Other _____

List all **current medications** including prescriptions, birth control pills, non prescription, and dietary supplements: _____

Have there been any **changes in your health in the past 12 months**? If yes, explain:

Have you ever been **hospitalized for any condition**? Yes ___ No ___ Explain:

Social History:

Have you ever smoked **cigarettes/other substances** ? YES ___ NO ___

How long did you smoke? _____ How much? _____

How much **alcohol** do you consume per week? _____

Do you use illicit/illegal drugs? YES ___ NO ___

If yes, what kind: _____

Were you ever treated for **drug/alcohol addiction**? If yes, describe:

Do you have any body piercing? YES ___ NO ___ Do you use **seat belts**? YES ___ NO ___
Do you have any tattoos? YES ___ NO ___ Do you use **sun block**? YES ___ NO ___

Are you in a relationship or situation with someone who is physically or psychologically abusive?
Or threatens to hurt you? _____

Does anyone control most of your daily activities? For instance do they tell you who you can be
friends with or how much money you can take when you go shopping Yes ___ No ___

Name _____

Occupational History:

Have you ever had a splash or **Blood Borne Pathogen Exposure**? Yes ___ No ___

Date: _____ did you have **BBPE follow up**? Yes ___ No ___

If your job involves work at a computer, have you had or are you experiencing any discomfort, pain, or numbness when working at your desk? Yes ___ No ___

Have you ever had an occupational injury/illness before (e.g., back strain, chemical? Exposure)? Yes ___ No ___ **If Yes, describe** _____

Work History:

Date last worked: _____ Where? _____

Medical discharge from military? Yes ___ No ___

Have you ever been exposed/worked around to hazardous/toxic chemicals/conditions? If yes, explain:

In completing this questionnaire on my health history, I certify that the above information is true and correct to the best of my knowledge. I agree to all tests including labs, chest x-ray, and/or immunizations which are required /recommended by the N.Y State Department of Health.

Check all that apply: If checked, explain in detail

- | | | |
|--|--|---|
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thoughts of harming self or others |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Weight Loss/Gain | | |

If checked, explain in detail:

Have you ever tested positive for a **Tuberculin Skin Test (TST)**? Yes ___ No ___

If tested positive, what year ___? Were you treated? Yes ___ No ___ Chest x-ray Date ___ Results ___

If yes, what medication were you treated with? _____ How long? _____

Employee/Volunteer Signature: _____ **Date:** _____

Review of Systems: _____

Healthcare Provider Signature: _____ **Date:** _____

OHS NP OHS MD PCP OHS RN

PLEASE SUBMIT IMMUNIZATION RECORDS AND BLOOD TITER RESULTS FOR MEASLES, MUMPS, RUBELLA, VARICELLA, HEPATITIS B ANTIBODY AND HEPATITIS B ANTIGEN

Revised 02/11/14



Occupational Health Services
Contact Form
212-606-1389

Today's Date: _____ DOB: _____ Marital Status: _____ M F
Name: _____ Social Security#: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Cell Phone #: _____ Email Address: _____
Personal Physician: _____ Phone: _____
Physician Address: _____

Emergency Contact Name: _____
Emergency Contact Phone #: _____
Relationship: Mother Father Spouse Other
For volunteers under 18 : Date of Birth of Parent/Legal Guardian: _____
Address of Emergency Contact: _____

HSS Work Department: _____ Location: _____
Position/Title: _____ Extension: _____
Supervisor: _____ Extension: _____
Work Status: Full Time Part Time Per Diem
Shift: Days Evenings Nights