Axiom Medical Consulting, LLC | **MEDICAL HISTORY** | **Medical Confidential**

Name (Last, First)				Social Security Number	Today's Date
Birthdate	Age	Sex	Race	Company Name & Work Location	
Home Phone		Work Phone		Job Title or Assignment	

Home Address (Street, City, State and Zip Code)

Examination Type (check appropriate box)

☐ Pre-Placement ☐ DOT ☐ HAZWOPER ☐ Audiogram ☐ Respirator ☐ Other (list type) _____

If you currently have the medical condition listed below check 'Now'. If you had it in the past check 'Past'. If you never had the condition check 'Never'.

Never	Now	Past	Patient History
☐	☐	☐	1. Have you been turned down for a job, for the armed services, or for insurance because of health or because of a physical examination? Please specify below.
☐	☐	☐	2. Have a physical or health problem (specify) _____
☐	☐	☐	3. Have received Workers' Compensation
☐	☐	☐	4. Have allergies (specify) _____
☐	☐	☐	5. Consume alcohol on a regular basis? List number of drinks consumed in the average week _____
☐	☐	☐	6. Average number of cigarettes smoked or chewing tobacco each day (now or in past). If former smoker, when did you quit? _____
☐	☐	☐	7. Have had surgery (specify and enter date of surgery) _____
☐	☐	☐	8. Have had a major or serious non-occupational injury or illness (specify) _____
☐	☐	☐	9. Prescription medication use (if now, specify name, dosage, frequency & last dose) _____
☐	☐	☐	10. Non-prescription medication use (if now, specify name, dosage, frequency & last dose) _____
☐	☐	☐	11. Any eye illness (i.e., cataracts, glaucoma, etc.) _____
☐	☐	☐	12. Loss of hearing
☐	☐	☐	13. Any ear illness (i.e., ringing, buzzing, etc.) (specify) _____
☐	☐	☐	14. Respiratory (lung) disease (i.e., pneumonia, bronchitis, pleurisy, TB, etc.) _____
☐	☐	☐	15. Hypertension (high blood pressure). List medications, if any _____
☐	☐	☐	16. Any heart disease (i.e., chest pain, heart failure, heart attack, etc.) _____
☐	☐	☐	17. Any circulatory problems (i.e., cramps in legs when walking, varicose veins, stroke, etc.) _____
☐	☐	☐	18. Recurrent or persistent pain or stiffness in back, including neck (specify) _____
☐	☐	☐	19. Bone, joint, or muscle problems, including amputations and fractures (specify) _____
☐	☐	☐	20. Hernia (specify when, date repaired if applicable, & type; e.g. inguinal, umbilical, etc.) _____
☐	☐	☐	21. Any gastrointestinal disease (i.e., ulcer, colitis, blood in bowel movement, etc.) _____
☐	☐	☐	22. Any kidney or bladder disease
☐	☐	☐	23. Recurrent headaches
☐	☐	☐	24. Epilepsy (convulsions, seizures). Date of last episode, if applicable _____
☐	☐	☐	25. Mental or emotional disease (specify type) _____
☐	☐	☐	26. Neurological disease (specify) _____
☐	☐	☐	27. Endocrine or metabolic disorder (i.e., gland, diabetes, etc.) _____
☐	☐	☐	28. Any blood disease (i.e., anemia, leukemia, clotting problem, etc.) _____
☐	☐	☐	29. Any skin disease (specify) _____
☐	☐	☐	30. Infection of uterine tube, pelvic inflammatory disease (specify) _____
☐	☐	☐	31. Pregnant
☐	☐	☐	32. Other abnormal findings or diseases not covered elsewhere in this questionnaire (specify) _____

Additional space for comments

I certify that all my responses are true to the best of my knowledge.	Patient Signature	Date