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DEVELOPMENT OF MEDICAL AND OCCUPATIONAL HISTORY FORMS FOR THE NAVY OCCUPATIONAL HEALTH INFORMATION MANAGEMENT SYSTEM

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REPORT NO. 85-2

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Development of Medical and Occupational History Forms for
the Navy Occupational Health Information Management System

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Report No. 85-2, supported by the Naval Medical Research and Development Command, (Department of the Navy) Bethesda, Maryland, under Research Work Unit M0933-PN.003-000). The views presented in this paper are those of the authors. No endorsement by the Department of the Navy has been given or should be inferred.

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Development of Medical and Occupational History Forms for the Navy Occupational
Health Information Management System

INTRODUCTION

Occupational health programs are multidisciplinary in nature, involving primarily the fields of occupational medicine, epidemiology, industrial hygiene and toxicology. The computerized occupational health information system, to be maximally effective, should incorporate, as a minimum, the following types of information: (a) detailed worker and job histories and demographic data; (b) an inventory of possible exposures and their potential adverse health effects related to specific workplace location; (c) worksite exposure data, and (d) employee medical information collected throughout the worker's career.

The objective of the Navy Occupational Health Information Management System (NOHIMS) is to provide an information system that will coordinate the components of the Navy's occupational health program in order to satisfy the requirements of the Occupational Safety and Health Act of 1970 (1) by helping to provide a safe and healthful working environment for all employees in Navy industrial facilities.

In order to provide the information needed to coordinate the components of the Navy's occupational health programs, NOHIMS utilizes a database consisting of three basic types of data entered into the system on a continual basis. These data comprise the personnel, environmental and medical files and are discussed in detail elsewhere (2-4).

A presentation of the types of information contained in the NOHIMS database is shown in Figure 1. In this figure, personnel (occupational histories) and environmental (industrial activities, workplace environments and hazard profiles) data, for the worker population, are subsumed under the more general label of occupational health data. This report describes the initial development of the encounter forms that are designed to collect individual medical and occupational data elements and establish a baseline information base.

DESIGN AND DEVELOPMENT

Department of Defense (5) and Department of the Navy (6-8) instructions have directed the establishment of comprehensive, aggressive and effective occupational safety and health programs in support of the Occupational Safety and Health Act (1). Among other tasks, these instructions require "...periodic surveillance to confirm or detect early presymptomatic exposure to health hazards, materials and environments at the worksite." Compliance with these instructions has engendered the need to develop a comprehensive record system that can monitor and document employee health and exposure patterns for extended periods of time.

The ascertainment of an individual's previous medical, occupational health care and job experience histories requires a full understanding of a worker's current health status and the potential impact on health risk and future job performance. Cogent and timely use of such information would contribute to more informed medical and administrative decision-making in terms of job placement and health risk.

Various corporate and medical surveillance information systems (9) and other sources (10-11) provided guidance for the basic structural design and identification of key data elements nec-

essary to provide detailed medical and occupational histories. An essential requirement of these data elements is that they be coded and formatted in a manner that is compatible with other medically related NOHIMS modules. The Computer Stored Ambulatory Record (COSTAR) medical information system satisfies this criterion. COSTAR provides extensive user help, aids, and explanation techniques and is written in the American National Standards Institute (ANSI) standard MUMPS language (2) recently approved for use by DOD (12).

Appendices A and B represent the initial conceptual development of the medical and occupational history forms, respectively. These forms reflect a concerted effort to provide a comprehensive medical and occupational history based on information of importance to both the occupational physician and epidemiologist.

DESCRIPTION

Medical History Form - The Medical History Form (MEDHX) consists of 13 pages and is divided into four sections: family history (FH), past medical history (PMH), personal history (PH), and review of systems (ROS). The family history section requests information about various diseases or conditions that a worker's family members have or may have had in the past. The past medical history section asks the worker to answer questions concerning allergies, immunizations, use of medicines, hospitalizations and operations, injuries, and treatments for other than minor conditions over the past five years. Some basic demographic information including marital and veteran status is ascertained in the personal history section. In addition, information about lifestyle habits such as smoking, alcohol consumption and exercise is requested in this section. The final section of the medical history form provides a comprehensive review of body and organ systems. All of the items covered in the Report of Medical History (SF-93) have been integrated into this section in addition to other pertinent medical information. Systems reviewed include the skin, eyes, ears and hearing, nose-throat-mouth-teeth, respiratory and cardiovascular systems, gastrointestinal, urinary and reproductive systems, musculoskeletal and nervous systems, and a miscellaneous category to cover diseases or conditions that do not fall under any of the other systems.

Occupational History Form - The basic format of the Occupational History Form (OCCHX) consists of 6 pages and is divided into three primary sections: occupational exposure inventory (OEI), environmental history (ENV), and chronological occupational profile (COP). The occupational exposure inventory section requests information concerning previous work-related injuries or health problems that may have led to lost work time, or refusal of employment or compensation. The environmental history section gathers information about various non-work related hazardous exposures encountered by the respondent (e.g., type of home heating and cooking devices, hobbies, and domestic chemical exposures). These two sections will be completed once during the pre-employment medical examination with changes submitted on an annual basis, or as required. The final section, chronological occupational profile, asks the respondent about his or her employment status (current or most recent job), health problems or injuries, hazardous exposures and use of personal protective equipment related to this job. The COP will be completed for all jobs (including military service) that an individual has held since high school or age eighteen.

IMPLEMENTATION

The current implementation plans are to conduct initial testing of the Medical and Occupational History forms at the Civil Service Dispensary located at the North Island Naval Air Station, San Diego, California. The forms will be completed by prospective employees of the Naval Air Rework Facility during the preliminary phases of their pre-employment medical examination. Although the prototype NOHIMS application is directed towards civilian employees, use of these forms can be easily adapted to other industrial activities at North Island employing both civilian and military personnel. Upon final acceptance and dissemination of NOHIMS, all civilian employees and military personnel who have not previously filled out these forms will be required to do so on a one-time basis. A periodic (usually annual) update of a worker's medical, home environment and occupational status will be conducted to determine if there have been any changes in health risk. Information from the completed forms will be reviewed by an occupational physician and/or nurse and entered into NOHIMS by data entry clerks.

DISCUSSION

The use of the Medical and Occupational History forms will provide a comprehensive summary of an individual's medical, employment and exposure history throughout his or her adult life and help establish a valuable baseline. For example, if a person starts working at a Naval activity with a physical or medical impairment incurred prior to this employment, the government needs to document that fact. Such workers would be identified via the Medical and Occupational History Forms. This type of information would be valuable in determining appropriate job placement and/or medical care, if warranted.

One must keep in mind that with the exception of verifiable demographic data (social security number, age, veteran status), most of the other information is based on an individual's memory and, therefore, may be subject to recall bias. The standardization and structure of the forms and clear and concise wording of the questions will lessen the likelihood of this type of bias.

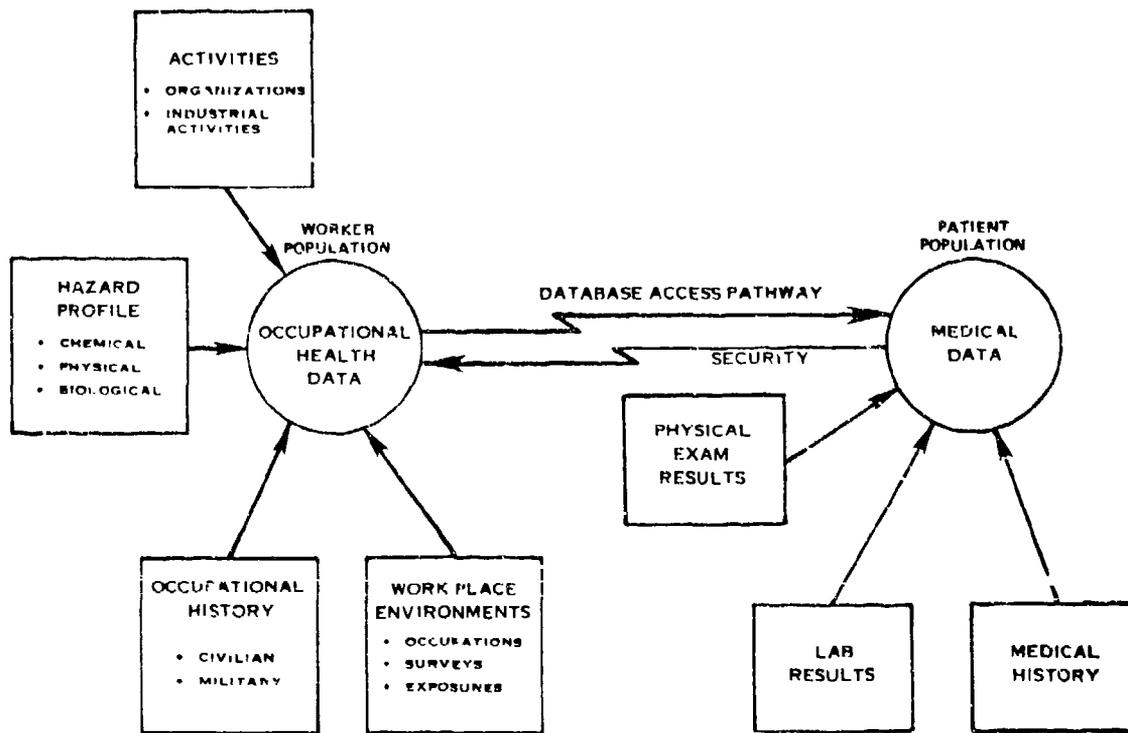
The storage of information in computers greatly increases the ease of information retrieval and, consequently, the potential for epidemiological studies. Preservation of this potential may be realized by maximizing input from the employee during the initial encounter.

The length of the forms and the time required to complete them may raise concerns from both management and medical personnel especially in terms of lost production time and increased medical review and data entry time. An additional concern may be the limits of worker attention span and endurance in completing the forms. This point is especially relevant depending on the number of primary jobs that an individual has had during his or her years of employment.

These forms represent the initial effort to consolidate all pertinent medical, occupational and exposure information into a comprehensive data file. Following field testing, design changes and additions or deletions of data elements may be expected. The ensuing modifications of these initial forms, then, will represent an effort to strike a reasonable balance between the scientific goals and practical considerations described.

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TYPES OF INFORMATION CONTAINED IN THE NOHIMS DATABASE

Figure 1

APPENDIX A

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
FH/PMH

Please answer the following questions about your medical history as best you can. Afterwards, the nurse or doctor will go over your answers with you in private.

NOTE All of this information remains part of your confidential medical record. It can be released only by your signed permission. The information will be used to help provide better medical services to you.

OFFICE USE ONLY			
SOCIAL SECURITY NUMBER	TODAY'S DATE	PROVIDER NO. 1	PROVIDER NO. 2
-----	MONTH / DAY / YEAR	LAST NAME -----	LAST NAME -----

FAMILY HISTORY (FH)

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING CONDITIONS OR DISEASES? ("Family" includes Mother, Father, Brother, Sister, Grandparent, Aunt, Uncle, or Children.)

Check only one box for each question.

	(Y)ES	NOT (S)URE	NO
(ADB-) Anemia, blood disease, or bleeding tendency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(AHL-) Asthma, hayfever, or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(BDF-) Birth defect(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(CTM-) Cancer or tumor(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DBT-) Diabetes (sugar disease)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(EPR-) Epilepsy, "fits" or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(HTP-) Heart trouble (including angina), high blood pressure, or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(OFD-) Some other disease(s) or condition(s) not given above which runs in your family? If you checked YES or NOT SURE, please specify the disease(s) or condition(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR OFFICE USE ONLY
(FNG)
All neg ans

PAST MEDICAL HISTORY (PMH)

ALLERGIES

Check only one box.

	(Y)ES	NOT (S)URE	(N)O
(PRX-) Have you ever had any allergic or adverse reaction (hives, skin rash, itching, swollen eyes, trouble with breathing, etc.) from any medicine, drug, food substance, or material of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES or NOT SURE, list the year(s) [as best you can] and the substance(s) [if known] that caused the allergic or adverse reaction(s).

(AY1) Year (Write in) 19 ____	(AY2) Year (Write in) 19 ____
(AS1) Substance (Write in) _____	(AS2) Substance (Write in) _____
(AY3) Year (Write in) 19 ____	(AY4) Year (Write in) 19 ____
(AS3) Substance (Write in) _____	(AS4) Substance (Write in) _____
(AY5) Year (Write in) 19 ____	(AY6) Year (Write in) 19 ____
(AS5) Substance (Write in) _____	(AS6) Substance (Write in) _____

MHRC [11-13-84]

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OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
PMH

PAST MEDICAL HISTORY (PMH) (CONT.)

IMMUNIZATIONS

HAVE YOU HAD A:

Check only one box for each question.

	(Y)ES	NOT (S)URE	(N)O
(TMM-) Tetanus immunization in the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DMH-) Diphtheria immunization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PMH-) Polio immunization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICINES

ARE YOU TAKING ANY OF THESE MEDICINES REGULARLY (at least once per week)? (SF 93/8)

	(Y)ES	NO	
(APR-) Aspirin (includes Ascripton, Bufferin, Anacin, or other medicines containing aspirin) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(ATB-) Antibiotics (drugs to control infections such as penicillin) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(AAH-) Allergy/asthma medicine (during last 12 months) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(BPH-) Blood pressure medicine specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(BT-) Blood thinner (anticoagulant) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(DRT-) Diuretics (water pills) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(IPD-) Insulin for diabetes Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(PCD-) Pills or capsules for diabetes Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(LXT-) Laxatives Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(MSZ-) Medicine for seizures or convulsions (epilepsy) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(NDH-) Nitroglycerin, Digoxin, or other heart medicine Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(SHD-) Stomach medicine (e.g., Tums, Rolaids, Gelucil) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(TMD-) Thyroid medicine Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(TQS-) Tranquilizers or sleeping pills (e.g., Librium, Valium, Thorazine) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(NDV-) Vitamins (high dosage only) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(BCP-) Birth control pills Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
(STP-) Steroid (e.g., Cortisone) pills or capsules Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	

(MTR) List the names of any other medicines that you take regularly (at least once per week). (SF 93/8)

FOR OFFICE USE ONLY

(MDNG)

All neg ans

Check only one box.

	(Y)ES	NOT (S)URE	(N)O
(SDM-) Have you ever had an adverse or allergic reaction to any serum, drug, or medicine? (SF 93/11-29).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF YES or NOT SURE, please describe the reaction. _____

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
PMH

PAST MEDICAL HISTORY (PMH) (CONT.)

HOSPITALIZATIONS AND OPERATIONS

LIST ALL HOSPITAL ADMISSIONS AND OPERATIONS FOR ANY REASON. (SF 93/18419)

IF NONE, CHECK HERE: (NHS) No hospitalization(s) and/or operation(s)

If any, please describe the hospitalization(s) and/or operation(s) below.

<p style="text-align: center;"><u>BOX 1</u></p> <p>(HP1) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><u>BOX 2</u></p> <p>(HP2) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>
<p style="text-align: center;"><u>BOX 3</u></p> <p>(HP3) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><u>BOX 4</u></p> <p>(HP4) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>
<p style="text-align: center;"><u>BOX 5</u></p> <p>(HP5) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><u>BOX 6</u></p> <p>(HP6) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>
<p style="text-align: center;"><u>BOX 7</u></p> <p>(HP7) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><u>BOX 8</u></p> <p>(HP8) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>
<p style="text-align: center;"><u>BOX 9</u></p> <p>(HP9) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><u>BOX 10</u></p> <p>(HP10) Year (Write in) 19 ____</p> <p>Reason (Write in) _____</p> <p>Name of Hospital, City, and State (Write in) _____</p> <p>_____</p> <p>_____</p>

Check only one box.

(Y)ES NOT (S)URE (N)O

(ADV-) Were you ever advised to have an operation that you did not have? (SF 93/18)

If YES or NOT SURE, describe. _____

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

PH/CHX
PMH

PAST MEDICAL HISTORY (PMH) (CONT.)

INJURIES

(SIJ-) Have you ever had any serious injuries? (SF 93/20) (Y)ES NOT (S)URE (N)O
Check only one box.

If YES or NOT SURE, please describe the injury(ies) below.

(SJ1) Year (Write in) 19 ___ (SJ2) Year (Write in) 19 ___
Injury (Describe) _____ Injury (Describe) _____

(SJ3) Year (Write in) 19 ___ (SJ4) Year (Write in) 19 ___
Injury (Describe) _____ Injury (Describe) _____

(SJ5) Year (Write in) 19 ___ (SJ6) Year (Write in) 19 ___
Injury (Describe) _____ Injury (Describe) _____

TREATMENTS

(CTC-) Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (SF 93/21) (Y)ES NOT (S)URE (N)O
Check only one box.

If you have consulted or been treated or are NOT SURE, please describe the treatment(s) below.

(CT1) Year (Write in) 19 ___ (CT2) Year (Write in) 19 ___
Name and Address of Doctor, Clinic, etc. _____ Name and Address of Doctor, Clinic, etc. _____

Treatment (Describe) _____ Treatment (Describe) _____

(CT3) Year (Write in) 19 ___ (CT4) Year (Write in) 19 ___
Name and Address of Doctor, Clinic, etc. _____ Name and Address of Doctor, Clinic, etc. _____

Treatment (Describe) _____ Treatment (Describe) _____

(MHN-) How is your health now? (SF 93/8) (E)XCELLENT (G)OOD (F)AIR (P)OOR (D)ON'T KNOW
Check only one box.

(MDD-) Do you have a doctor (or doctors)? Check only one box. (Y)ES NOT (S)URE (N)O

If you have a doctor or doctors, please identify below.

(DN1) Name _____ (DN2) Name _____
Address _____ Address _____

(DN3) Name _____ (DN4) Name _____
Address _____ Address _____

(MLR-) If you do not have a doctor, would you like us to refer you to a doctor? Check only one box. (Y)ES (D)ON'T KNOW (N)O

MHRC [11-13-84]

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
PH

PERSONAL HISTORY (PH)

Check one box for each question unless otherwise indicated.

(LVE-) Have you lived in or visited other parts of the USA or foreign countries in the last 5 years? (Y)ES (N)O

If YES, specify where. _____

(MST-) What is your marital status?
 (K)ever married (S)eparated (W)idow(er)
 (M)arried (D)ivorced

(CV-) Are you a veteran or currently in the Armed Forces? (Y)ES (N)O

(RMS-) Have you ever been rejected for military service because of physical, mental, or other reasons? (SF 93/22). (Y)ES (N)O

If YES, give date and reason for rejection.

(DMS-) Have you ever been discharged from military service because of physical, mental, or other reasons? (SF 93/23). (Y)ES (N)O

If YES, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.

SMOKING - CIGARETTES

(MSCG-) Do you now or have you ever smoked cigarettes? (Y)ES (N)O

If NO, go to the next section on SMOKING - PIPES AND CIGARS.

(BSC) If YES, at what age did you begin? Specify age _____ (Y)ES (N)O

(SMC-) Do you smoke now? (Y)ES (N)O

(AQS) If you have quit, at what age did you do so? Specify age _____

(PCS-) How much do/did you smoke (on the average)?
 (A) Less than 1 pack per day (C) More than 1 pack, but less than 2 packs per day
 (B) One pack per day (D) More than 2 packs per day

(SWJ-) Do you smoke while on the job? (Y)ES (N)O

SMOKING - PIPES AND CIGARS

(SFC-) Do you smoke a pipe or cigars? (Y)ES (N)O

If NO, go to the next section on EXERCISE.

(YPC) How many years have you smoked a pipe or cigars? Specify years _____

(IHS-) Do you inhale when smoking a pipe or cigars? (Y)ES (N)O NOT (S)URE

MMAC [11-13-84]

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
PH

PERSONAL HISTORY (PH) (CONT.)

EXERCISE

Check one box for each question unless otherwise indicated.

- (ASP-) Do you exercise or engage in active sports REGULARLY (such as jogging, cycling, swimming, dancing, etc.)? (Y)ES (N)O NOT (S)URE
- (TPW-) IF YES, how many times a week do you do that?
 (A) Less than 1 (C) 2 (E) 4 or more
 (B) 1 (D) 3
- (LAJ-) What is your usual level of activity on your job?
 (S)edentary (mostly sitting)
 (M)oderate (some sitting, some walking)
 (A)ctive (active physical labor)

ALCOHOL

Check one box for each question unless otherwise indicated.

- (DBV-) Do you drink alcoholic beverages (liquor, wine, beer)? (Y)ES (N)O
- If NO, go to the next section on the SKIN.
- If YES, how often do you drink each of the following types of drinks?
 Check one box for each type of drink.
- | | (A)
None | (B)
Less than one
day per week | (C)
1-2 days
per week | (D)
3-4 days
per week | (E)
5-7 days
per week |
|----------------|--------------------------|--------------------------------------|-----------------------------|-----------------------------|-----------------------------|
| (BEER-) Beer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (WINE-) Wine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (LIQ-) Liquor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- (AAB-) On each day that you drink an alcoholic beverage, about how much do you usually drink? (if you drink more than one kind of alcoholic beverage, give the total number of beers plus glasses of wine plus number of highballs or cocktails.)
 (A) 1-2 (C) 5-6 (E) 9 or more
 (B) 3-4 (D) 7-8
- (DKP-) Do you or does a person close to you consider your drinking to be a problem? (Y)ES NOT (S)URE (N)O
- If YES or NOT SURE, do you wish to speak to a doctor or nurse in private about obtaining counseling?

MHRC [1-13-84]

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
ROS

REVIEW OF SYSTEMS (ROS)

SKIN

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

(SRS-) Skin rash (including hives)? (Y)ES (N)O (S)URE (N)O

(CZ-) If YES or NOT SURE, what was/were the cause(s) of the skin rash? Check ALL that apply.

- (C)lothing
- (J)ewelry
- (S)oap
- (T)oiletries or cosmetics
- (M)edicine
- Sun(l)ight
- (F)ood
- (P)oison Ivy
- (W) Something in the workplace (Specify) _____
- (O*) Cause other than previously listed (Specify) _____
- (U) Cause unknown or not certain

(MLS-) Moles that have changed in size or color, or that have not healed? (Y)ES (N)O (S)URE (N)O

DID A DOCTOR EVER TELL YOU THAT YOU HAD:

(SKD-) Skin disease(s)? (SF 93/11-14). (Y)ES (N)O (S)URE (N)O

(DDS-) If YES or NOT SURE, specify the disease. Check ALL that apply.

- (P)soriasis
- (S)kin cancer
- (O*)ther (Specify) _____

(OSP-) Do you now have or have you ever in the past had any skin problems not covered above? (Y)ES (N)O (S)URE (N)O

If YES or NOT SURE, specify. _____

FOR OFFICE USE ONLY

(SNG)

All neg ans

EYES

Check one box for each question unless otherwise indicated.

(VSN-) Do you now have vision in both eyes? (SF 93/10B) (Y)ES (N)O (S)URE (N)O

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

(ETR-) Eye trouble? (SF 93/11-6) (Y)ES (N)O (S)URE (N)O

(SYJ-) Serious eye injury (more than 2 days off work)? (Y)ES (N)O (S)URE (N)O

(ESG-) Eye surgery? (Y)ES (N)O (S)URE (N)O

(FQI-) frequent eye infections (e.g., conjunctivitis, pink eye)? (Y)ES (N)O (S)URE (N)O

(SBA-) Severe itching, burning, redness, or swelling of the eyelids? (Y)ES (N)O (S)URE (N)O

DID A DOCTOR EVER TELL YOU THAT YOU HAD:

(GLC-) Glaucoma (pressure on the eyeball)? (Y)ES (N)O (S)URE (N)O

(CTR-) Cataracts? (Y)ES (N)O (S)URE (N)O

(GLS-) Do you wear glasses? (SF 93/10A) (Y)ES (N)O (S)URE (N)O

(CLS-) Do you wear contact lenses? (SF 93/10A) (Y)ES (N)O (S)URE (N)O

(OYP-) Do you now have or have you in the past year had any eye problem(s) not covered above? (Y)ES (N)O (S)URE (N)O

If YES or NOT SURE, specify. _____

FOR OFFICE USE ONLY

(YNG)

All neg ans

OHRC (11-13-84)

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
ROS

REVIEW OF SYSTEMS (ROS) (CONT.)

EARS AND HEARING

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

- | | (Y)ES | NOT (S)URE | (N)O |
|---|--------------------------|--------------------------|--------------------------|
| (EWT-) Ear, nose, or throat trouble? (SF 93/11-7) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (DPH-) Any difficulty hearing or a hearing loss? (SF 93/11-8) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (RHLS-) If Y, have you noticed a recent hearing loss? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (HRGD-) Worn a hearing aid? (SF 93/10C) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (RBZ-) Ringing or buzzing in your ears once a week or more? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (TRBZ-) If YES or NOT SURE, how long have you had this? | | | |
| <input type="checkbox"/> (A) Less than 2 months <input type="checkbox"/> (B) 2-5 months <input type="checkbox"/> (C) 6-23 months <input type="checkbox"/> (D) 2 years or more | | | |

- | | (Y)ES | NOT (S)URE | (N)O |
|--|--------------------------|--------------------------|--------------------------|
| (CDS-) Constant discharge (drainage of fluid) from your ears, or frequent infections in your ears? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (RDS-) Regularly engaged in these sports or hobbies: scuba diving, or shooting (firearms), chain sawing, snowmobiling, motorcycling, rock music, or others with loud noise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (OED-) Any other ear difficulty not covered above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES or NOT SURE, specify. _____ | | | |
| _____ | | | |
- FOR OFFICE USE ONLY
(HNG)
All neg ans

NOSE THROAT SINUSES MOUTH TEETH GUMS

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

- | | (Y)ES | NOT (S)URE | (N)O |
|---|--------------------------|--------------------------|--------------------------|
| (NFV-) Hay fever? (SF 93/11-12) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (NCG-) Nasal congestion, persistent running nose, sinus congestion, or sinusitis? (SF 93/11-11) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (PNF-) Painful, swollen, or bleeding gums, or tooth trouble? (SF 93/11-10) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (OCP-) Any other trouble with your nose, throat, sinuses, mouth, teeth, or gums not covered above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES or NOT SURE, specify. _____ | | | |
| _____ | | | |
- FOR OFFICE USE ONLY
(EONG)
All neg ans

NHRC (11-13-84)

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
ROS

REVIEW OF SYSTEMS (ROS) (CONT.)

RESPIRATORY SYSTEM

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

	(Y)ES	NOT (S)URE	(N)O
(PCD-) Frequent (more than 3 per year) or long-lasting (2 weeks or more) colds? (SF 93/11-9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(CNC-) Chronic cough (almost everyday)? (SF 93/11-20)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(AYC-) If YES or NOT SURE, during how many months of the year do you have this cough? <input type="checkbox"/> (A) Less than 3 months <input type="checkbox"/> (B) 3-6 months <input type="checkbox"/> (C) More than 6 months			
(LTC-) If YES or NOT SURE, how long have you had this cough? <input type="checkbox"/> (A) Less than 2 years <input type="checkbox"/> (B) 2-5 years <input type="checkbox"/> (C) More than 5 years			
(CRB-) If YES or NOT SURE, do you ever cough up red blood? (SF 93/9B) <input type="checkbox"/> (Y) Yes <input type="checkbox"/> (N) No			
(TCW-) Tightness of the chest or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S)URE	(N)O
(ASH-) Asthma? (SF 93/11-17)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(EMC-) Emphysema or chronic bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(TB-) Tuberculosis (TB)? (SF 93/11-16)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(RTW-) Do you notice that when you return to work after being away for a few days (weekend or holiday) you get coughing, wheezing, or tightness of the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(LVT-) Have you ever lived with anyone who had tuberculosis (TB)? (SF 93/9A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(CRP-) Do you now have or have you ever in the past had any other respiratory or breathing problem(s) not covered above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES or NOT SURE, specify: _____

FOR OFFICE USE ONLY
(ASNG)
All neg ans

CARDIOVASCULAR SYSTEM

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

	(Y)ES	NOT (S)URE	(N)O
(SHB-) Shortness of breath (not the normal kind with severe exercise)? . . . (SF 93/11-18)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(TPC-) Tightness, pain, heaviness, squeezing, or pressure in your chest? . . (SF 93/11-19)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PLP-) Palpitations, pounding heart, or irregular heart beats (other than when you were upset, excited, or exercising)? (SF 93/11-21)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S)URE	(N)O
(HBP-) High blood pressure (hypertension)? (SF 93/11-23)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(LBP-) Low blood pressure? (SF 93/11-23)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(HTR-) Heart trouble? (SF 93/11-22)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(STRK-) A stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PHLB-) Phlebitis (deep vein trouble in the legs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(SPF-) Scarlet fever or erysipelas? (SF 93/11-1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(RHF-) Rheumatic fever? (SF 93/11-2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(LVR-) Do you limit your walking because of leg pain (cramps in your legs)? (SF 93/11-24)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(HCP-) Do you now have or have you ever in the past had any other problem(s) with your heart or blood vessels not covered above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES or NOT SURE, specify: _____

FOR OFFICE USE ONLY
(CNG)
All neg ans

NHRC (11-13-84)

REVIEW OF SYSTEMS (ROS) (CONT.)

GASTROINTESTINAL SYSTEM

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

	(Y)ES	NOT (S)URE	(N)O
(FQD-) Frequent indigestion? (SF 93/11-25)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(SMH-) Stomach trouble? (SF 93/11-26)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(BTB-) Black, tar-colored, or bloody bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(CBH-) A change in your bowel habits (not explained by diet)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(HMP-) Hemorrhoids (piles) or rectal trouble? (SF 93/11-33)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DID A DOCTOR EVER TELL YOU THAT YOU HAD:

	(Y)ES	NOT (S)URE	(N)O
(DSU-) An ulcer (duodenal, stomach, or peptic)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DSG-) Gallbladder trouble or gallstones? (SF 93/11-27)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DSJ-) Jaundice, hepatitis, or liver trouble? (SF 93/11-26&28)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DTR-) Intestinal trouble (includes diseases of the colon)? (SF 93/11-26)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(OGP-) Do you now have or have you ever in the past had any other trouble(s) or disease(s) of the gastrointestinal system not covered above?

If YES or NOT SURE, specify: _____

FOR OFFICE USE ONLY
(GNG)

All neg ans

URINARY AND REPRODUCTIVE SYSTEMS

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

	(Y)ES	NOT (S)URE	(N)O
(BDB-) Bloody or dark brown urine (not dark yellow)? (SF 93/11-36)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(FPU-) Frequent or painful urination? (SF 93/11-34)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(FBK-) Frequent bladder or kidney infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PSD-) [MEN ONLY] Pain, swelling, or disease in your testicles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	(Y)ES	NOT (S)URE	(N)O
(FDS-) [WOMEN ONLY] Have you ever been treated for a female disorder? (SF 93/12A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(MSP-) [WOMEN ONLY] Have you ever had a change in menstrual pattern? (SF 93/12B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DID A DOCTOR EVER TELL YOU THAT YOU HAD:

	(Y)ES	NOT (S)URE	(N)O
(DKS-) Kidney stones ("gravel" in your urine)? (SF 93/11-36)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DVD-) Venereal disease ("VD") of any kind (including syphilis, gonorrhea, etc.)? (SF 93/11-38)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES or NOT SURE, specify the disease: _____

(ORU-) Do you now have or have you ever in the past had any problem(s) or disease(s) of the kidney, bladder, or reproductive system not covered above?

If YES or NOT SURE, specify: _____

FOR OFFICE USE ONLY
(UNG)

All neg ans

(TKK-) Have you ever tried to have children and had difficulty?

(Y)es, had difficulty Not (s)ure (N)o difficult.

(MCH-) Have you ever had any children (do not include foster children or adopted children)?

(Y)es Not (s)ure (N)o

(CVM-) If YES or NOT SURE, have you ever had a child who was malformed (congenital malformation, birth defect)?

(Y)es Not (s)ure (N)o

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
ROS

REVIEW OF SYSTEMS (ROS) (CONT.)

MUSCULOSKELETAL SYSTEM Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(RBP-) Recurrent back or neck pain so severe that it prevented you from performing your normal activities? (SF 93/11-45)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(LNB-) If YES or NOT SURE, where was the pain located? Check ALL that apply.			
<input type="checkbox"/> (L)ower back <input type="checkbox"/> (U)pper back <input type="checkbox"/> (N)eck			
(BBS-) To wear a brace or back support? (SF 93/10E)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(BSG-) Back surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES or NOT SURE, specify. _____			
(HRP-) Herniated or ruptured disc in your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(SPJ-) Swollen or painful joints? (SF 93/11-3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DBJ-) Deformity of bones or joints? (SF 93/11-41)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PTS-) Painful or "trick" shoulder or elbow? (SF 93/11-44)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PTK-) Painful, "trick", or locked knee, or knee that gives away? (SF 93/11-46)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(KSG-) Knee surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(LMW-) Lameness (inability to walk normally because of foot or leg difficulty)? (SF 93/11-42)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(FTR-) Foot trouble? (SF 93/11-47)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(LFT-) Loss of finger or toe? (SF 93/11-43)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(HFX-) Fracture(s) (broken bones)? (SI 93/11-30)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S)URE	(N)O
(ARB-) Arthritis, rheumatism, or bursitis? (SF 93/11-40)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(EMT-) Serious muscle or tendon injury (tendonitis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(RPH-) Rupture (hernia)? (SF 93/11-32)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES or NOT SURE, indicate year(s). _____			
HAVE YOU EVER HAD MORE THAN ONE YEAR EXPERIENCE (AT WORK OR WHILE ENGAGED IN A HOBY OR RECREATIONAL ACTIVITY) WITH ANY OF THE FOLLOWING:	(Y)ES	NOT (S)URE	(N)O
(MR-) Heavy, awkward, or repetitive lifting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(VBT-) Vibrating tools (jackhammer, sander, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(RRW-) Highly repetitive hand/wrist motion such as that required in certain types of hand tool or assembly operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(MPC-) If YES or NOT SURE to any of the three questions above, have you had any medical problems (pain, limitation of motion, etc.) connected with these activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES or NOT SURE, please describe. _____			
	(Y)ES	NOT (S)URE	(N)O
(NTF-) Do you have any numbness or tingling in your fingers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PWG-) Do you have any pain in your hands, wrists, or forearms, particularly when grasping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(OMP-) Do you now have or have you ever in the past had any other musculoskeletal problem(s) not covered above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES or NOT SURE, specify. _____			

FOR OFFICE USE ONLY
(MSG)
All neg ans

MHRL [11-13-84]

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
ROS

REVIEW OF SYSTEMS (ROS) (CONT.)

NERVOUS SYSTEM

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

	(Y)ES	NOT (S)URE	(N)O
(FQH-) Frequent or severe headaches? (SF 93/11-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DFB-) Dizziness, fainting spells, or blackouts? (SF 93/11-5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PRC-) Periods of unconsciousness? (SF 93/11-56)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PLY-) Paralysis (including polio)? (SF 93/11-49)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(SHK-) Shaking, tremor, or trembling of the hands (except when you were temporarily frightened or upset)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(EPZ-) Epilepsy or seizures ("fits")? (SF 93/11-50)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(HJC-) Head injury resulting in loss of consciousness? (SF 93/11-13)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(NRT-) Neuritis? (SF 93/11-48)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(MSK-) Motion sickness (car, train, sea, or air sickness)? (SF 93/11-51)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(TSC-) Attempted suicide? (SF 93/90)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(WAL-) Walking in your sleep? (SF 93/91)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(MNS-) Amnesia (loss of memory)? (SF 93/11-54)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(FTS-) Frequent trouble sleeping? (SF 93/11-52)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DPW-) Depression or excessive worrying? (SF 93/11-53)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(STH-) A problem with stuttering or stammering? (SF 93/100)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(PSY-) Treatment for a psychiatric (mental) condition? (SF 93/16)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF YES or NOT SURE, specify where, year, and give details.

(ONP-) Other nervous trouble(s) of any sort not covered above? (SF 93/11-55)

IF YES or NOT SURE, specify: _____

FOR OFFICE USE ONLY
(NMG)
All neg ans

(HND-) Are you: (SF 93/14)

(R)ight handed (L)eft handed

MISCELLANEOUS

Check one box for each question unless otherwise indicated.

DID A DOCTOR EVER TELL YOU THAT YOU HAD:

	(Y)ES	NOT (S)URE	(N)O
(DBS-) Diabetes (or sugar in your urine)? (SF 93/11-37)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(TTC-) Thyroid trouble or goiter? (SF 93/11-15)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(GOT-) Gout?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(DSM-) Anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(UCA-) Cancer of any kind? (SF 93/11-31)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(KCA-) If YES or NOT SURE, what kind of cancer?
Check ALL that apply.

<input type="checkbox"/> (S)kin	<input type="checkbox"/> St(om)ach	<input type="checkbox"/> (B)lood (Leukemia)	<input type="checkbox"/> Bladder
<input type="checkbox"/> (H)ead or neck	<input type="checkbox"/> (C)olon	<input type="checkbox"/> L(ym)ph (Hodgkins)	<input type="checkbox"/> (K)idney
<input type="checkbox"/> (E)sophagus	<input type="checkbox"/> (L)ung		

MEN ONLY		WOMEN ONLY		MEN OR WOMEN	
<input type="checkbox"/> (P)rostate	<input type="checkbox"/> B(re)ast	<input type="checkbox"/> (U)terus	<input type="checkbox"/> (O)ther (Specify)		
<input type="checkbox"/> (T)esticle	<input type="checkbox"/> Cervix	<input type="checkbox"/> Ovary			

WHRC [11-13-84]

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

FDHXX
ROS

REVIEW OF SYSTEMS (ROS) (CONT.)

MISCELLANEOUS (CONT.) Check one box for each question unless otherwise indicated.

	(Y)ES	NOT (S)URE	(N)O
(TGC-) Did you ever have a noncancerous tumor, growth, or cyst? (SF 93/11-31)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES or NOT SURE, specify where [body part(s)] and when [year(s)].			

	(Y)ES	NOT (S)URE	(N)O
(CWT-) In the past 12 months have you had a change in your weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(WCH-) If YES or NOT SURE, weight gain or loss? (SF 93/11-39)			
<input type="checkbox"/> (A) Weight gain <input type="checkbox"/> (B) Weight loss			
(LBS-) If YES or NOT SURE, how much?			
<input type="checkbox"/> (A) Less than 10 lbs. <input type="checkbox"/> (C) 20-29 lbs. <input type="checkbox"/> (E) 40 lbs. or more			
<input type="checkbox"/> (B) 10-19 lbs. <input type="checkbox"/> (D) 30-39 lbs.			

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(BWT-) A problem with bed wetting (after age 12)? (SF 93/11-35)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(XB-) Excessive (too much) bleeding from a small cut or after having a tooth pulled? (SF 93/9C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(FNB-) Frequent nose bleeds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE USE ONLY
(FNC)
All neg ans

	(Y)ES	(N)O
(ILJ-) Have you ever had any illness or injury other than those already noted? (SF 93/20)	<input type="checkbox"/>	<input type="checkbox"/>
If YES, specify when, where, and give details.		

	(Y)ES	(N)O
(DLI-) Have you ever been denied life insurance? (SF 93/17)	<input type="checkbox"/>	<input type="checkbox"/>
If YES, state the reason and give details.		

	(Y)ES	(N)O
(ERD-) Have you ever received, is there pending, or have you applied for pension or compensation for an existing disability? (SF 93/24)	<input type="checkbox"/>	<input type="checkbox"/>
If YES, specify what kind, granted by whom, what amount, when, and why.		

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY

DCCHX
OEI/ENV

Please answer the following questions about your general occupational and environmental exposures as best you can. Afterwards, the nurse or doctor will go over your answers with you in private.

NOTE: All of this information remains part of your confidential medical record. It can be released only by your signed permission. The information will be used to help provide better medical services to you.

SOCIAL SECURITY NUMBER		TODAY'S DATE		OFFICE USE ONLY	
-----		MONTH / DAY / YEAR		PROVIDER NO. 1	PROVIDER NO. 2
SITE OF ENCOUNTER		TYPE		LAST NAME	LAST NAME
(A) North Island	(W) Occupational History for Job Number 1 of _____ (OFFICE USE ONLY)		VISIT CLASSIFICATION (OFFICE USE ONLY)		
				<input type="checkbox"/> (10) Reviewed	<input type="checkbox"/> (11) Not Reviewed

OCCUPATIONAL EXPOSURE INVENTORY (OEI)

(OWK-) Have you ever been off work for more than a day because of an illness or injury related to work? Check only one.

- (Y*) Yes (Please describe below.)
- (S*) Not sure

DO NOT WRITE IN THIS BOX

(N) No

(RSM-) Have you ever worked with any substance that caused you to break out in a rash? Check only one.

- (Y*) Yes (Please describe below.)
- (S*) Not Sure

DO NOT WRITE IN THIS BOX

(N) No

(CJ-) Have you ever changed jobs or work assignments because of any health problem(s) or injury(ies)? Check only one.

- (Y*) Yes (Please describe below.)
- (S*) Not Sure

DO NOT WRITE IN THIS BOX

(N) No

(RMP-) Have you been refused employment or been unable to hold a job or stay in school because of: Check ALL that apply. (SF 93-15)

- (A) Sensitivity to chemicals, dust, sunlight, etc.
- (B) Inability to perform certain motions.
- (C) Inability to assume certain positions.
- (D*) Other medical reasons (If checked, give reasons.)

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY

OCCHX
OEI/ENV

OCCUPATIONAL EXPOSURE INVENTORY (OEI) (CONT.)

(TBR-) Have you ever worked at a job that caused you trouble with breathing (includes cough, shortness of breath, or wheezing)? Check only one.

- (Y*) Yes (Please list jobs and describe below.)
 (S*) Not Sure

DO NOT WRITE IN THIS BOX

(N) No

(PDB-) Do you frequently have pain or discomfort in your back, or have you been under professional care for back problems in the past year? Check only one.

- (Y*) Yes (Please describe below.)
 (S*) Not Sure

DO NOT WRITE IN THIS BOX

(N) No

(VWC-) Did you ever receive compensation (VA, Workman's, etc.) for any of the above health problem(s) or injury(ies)? Check only one.

- (Y) Yes (S) Not Sure (N) No

ENVIRONMENTAL HISTORY (ENV)

(CRH-) Have you ever changed your residence or home because of a health problem?

- (N) No (Y*) (If Yes, describe briefly.)

(LMP-) Do you live next door to or very near an industrial plant?

- (N) No (Y*) (If Yes, describe briefly.)

(SHM-) Does your spouse or any other household member have contact with dusts or chemicals at work or during leisure activities?

- (N) No (Y*) (If Yes, describe briefly.)

(UPH-) Do you use pesticides and/or herbicides around your home or garden?

- (N) No (Y*) (If Yes, describe briefly.)

Which of the following do you have in your home? Check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> ACD Air Conditioner | <input type="checkbox"/> IB Indoor Barbecue | <input type="checkbox"/> KST Kerosene Stove |
| <input type="checkbox"/> APF Air Purifier | <input type="checkbox"/> MCW Microwave Oven | <input type="checkbox"/> CHT Central Heating |
| <input type="checkbox"/> HMF Humidifier | <input type="checkbox"/> FPL Fireplace | <input type="checkbox"/> HHO Other (Specify) _____ |
| <input type="checkbox"/> GST Gas Stove | <input type="checkbox"/> WBS Wood-burning Stove | ----- |
| <input type="checkbox"/> EST Electric Stove | <input type="checkbox"/> CBS Coal-burning Stove | ----- |

NHRC 11-6-84

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY

OCCHX
OEI/ENV

ENVIRONMENTAL HISTORY (ENV) (CONT.)

(EHC-) Do you now have or have you ever had a hobby or craft? Check only one.

(Y) Yes (S) Not Sure (N) No

If you have never had a hobby or craft, go to the CHRONOLOGICAL OCCUPATIONAL PROFILE on page 4.

If you have or have had a hobby or craft, complete one box below for each hobby or craft.

<p style="text-align: center;"><u>BOX 1</u></p> <p>(NC1) Name of hobby or craft: _____</p> <p>(YC1) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC1) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>	<p style="text-align: center;"><u>BOX 2</u></p> <p>(NC2) Name of hobby or craft: _____</p> <p>(YC2) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC2) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>	<p style="text-align: center;"><u>BOX 3</u></p> <p>(NC3) Name of hobby or craft: _____</p> <p>(YC3) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC3) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>
<p style="text-align: center;"><u>BOX 4</u></p> <p>(NC4) Name of hobby or craft: _____</p> <p>(YC4) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC4) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>	<p style="text-align: center;"><u>BOX 5</u></p> <p>(NC5) Name of hobby or craft: _____</p> <p>(YC5) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC5) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>	<p style="text-align: center;"><u>BOX 6</u></p> <p>(NC6) Name of hobby or craft: _____</p> <p>(YC6) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC6) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>
<p style="text-align: center;"><u>BOX 7</u></p> <p>(NC7) Name of hobby or craft: _____</p> <p>(YC7) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC7) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>	<p style="text-align: center;"><u>BOX 8</u></p> <p>(NC8) Name of hobby or craft: _____</p> <p>(YC8) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC8) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>	<p style="text-align: center;"><u>BOX 9</u></p> <p>(NC9) Name of hobby or craft: _____</p> <p>(YC9) How many years did you do/ have you done this hobby or craft? _____ Years</p> <p>(HC9) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk</p>

For all the hobbies or crafts you have or have had, check the hazardous substances you come/came in contact with by breathing, touching, or direct exposure while doing these hobbies or crafts.

(NHZ) No hazards that I know of

- | | | |
|---|--|---|
| <input type="checkbox"/> HACD Acids | <input type="checkbox"/> HNS Noise (loud) | <input type="checkbox"/> HWF Welding fumes |
| <input type="checkbox"/> HALC Alcohols (industrial) | <input type="checkbox"/> HSP Silica powder or sand-blasting dust | <input type="checkbox"/> HOS Other substance(s) |
| <input type="checkbox"/> HASB Asbestos | | (Specify) _____ |
| <input type="checkbox"/> HFG Fibrous glass | <input type="checkbox"/> HSL Solvents | _____ |
| <input type="checkbox"/> HHT Heat (severe) | <input type="checkbox"/> HVB Vibration | _____ |

NHRC [11-6-84]

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY

OCCHX
COP

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) FOR CURRENT JOB

Complete this section for your current job as best you can. If you are unemployed, complete this section for your last job.

EMPLOYMENT STATUS

(NCE) Name of employer: _____ (CSC) City, State or Country: _____
(TND) Type of Industry: _____ (HPW) Average number of hours worked per week: _____
(YS) Year started: 19 ____ (TNW) Total years worked there: _____
(YL) Year left: 19 ____ (TMW) Total months worked there (if less than one year): _____
(STL) Check box if Still employed

(YJT) What is/was your job title? (List ALL if more than one job title.)
1. _____
2. _____
3. _____
4. _____

(DJ) Briefly describe the duties of your job for each job title listed above.
1. _____
2. _____
3. _____
4. _____

JOB-RELATED HEALTH PROBLEMS OR INJURIES

(JRH-) While on this job, have you had/did you have any job-related health problems or injuries?
 (Y*) Yes (S*) Not Sure (N) No
If yes or not sure, briefly describe each problem or injury. DO NOT WRITE IN THIS BOX
1. _____
2. _____
3. _____
4. _____

(CJP-) If yes or not sure, do/did any of your co-workers have health problems or injuries while on this same job?
 (Y*) Yes (S*) Not Sure (N) No
If your co-workers have/had health problems or injuries, briefly describe each problem or injury. DO NOT WRITE IN THIS BOX
1. _____
2. _____
3. _____
4. _____

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY

OCCHX
COP

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) FOR CURRENT JOB (CONT.)

HEALTH HAZARDS

What known health hazards are/were present on this job? Check the appropriate boxes. Leave the boxes blank if the hazard was not present or if you are not sure that the hazard was present.

	(A) Check here if health hazard is/was present on the job.	(B) Also check here if you are/were in direct contact with it by breathing, touching, or other direct exposure.	Indicate how long you have been/were directly or indirectly exposed to the health hazard. YEARS MONTHS (Use whole numbers; no ranges) (Use whole numbers; no ranges)
(KHF-) Fibrous glass (fiberglass)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHA-) Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHC-) Coal dust or rock dust	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHS-) Silica powder or sandblasting dust	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHD-) Other specific dusts (wood,talc,lime).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHR-) Respiratory or skin irritants.	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHCH-) Chemicals (acids,alkalis,solvents)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHM-) Metal fumes (from molten metal).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHW-) Welding fumes.	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHL-) Coal tar, pitch, asphalt	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHE-) Engine exhaust, grease, oils, fuel	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHH-) Heat (severe).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHLD-) Cold (severe).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHN-) Noise (loud)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHZ-) Non-ionizing radiation	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHX-) Ionizing radiation (Xrays,etc.).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHV-) Vibration (vibrating tools,motors)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHG-) General shop dust.	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHP-) Pesticides, herbicides	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KH01-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KH02-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KH03-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KH04-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

(NPH) Check here if there are, were No health hazards on this job

If you did not check Chemicals in the question above,
go to the section on PROTECTIVE EQUIPMENT on page 6.

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY

OCCHX
COP

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) FOR CURRENT JOB (CONT.)

HEALTH HAZARDS (CONT.)

If you checked Chemicals in the previous question, which of the following chemicals are/were you exposed to, directly or indirectly? Check ALL that apply which you are sure you are/were exposed to.

- | | |
|---|---|
| <input type="checkbox"/> CACD Acids | <input type="checkbox"/> CKT Ketones |
| <input type="checkbox"/> CALC Alcohols (Industrial) | <input type="checkbox"/> CLD Lead (inorganic) |
| <input type="checkbox"/> CALK Alkalis (caustics) | <input type="checkbox"/> CMS Manganese |
| <input type="checkbox"/> CAMM Ammonia | <input type="checkbox"/> CMR Mercury (inorganic) |
| <input type="checkbox"/> CBNZ Benzene | <input type="checkbox"/> CMT Methylene chloride |
| <input type="checkbox"/> CBRY Beryllium | <input type="checkbox"/> CNK Nickel (inorganic) |
| <input type="checkbox"/> CCDM Cadmium | <input type="checkbox"/> CP Perchloroethylene |
| <input type="checkbox"/> CCOX Calcium oxide (lime dust) | <input type="checkbox"/> CPN Phenol |
| <input type="checkbox"/> CCOB Carbon monoxide | <input type="checkbox"/> CPS Phosgene |
| <input type="checkbox"/> CCT Carbon tetrachloride | <input type="checkbox"/> CPBB Polybrominated biphenyls (PBB's) |
| <input type="checkbox"/> CCN Chlorinated naphthalene | <input type="checkbox"/> CPCB Polychlorinated biphenyls (PCB's) |
| <input type="checkbox"/> CCLF Chloroform | <input type="checkbox"/> CSL Solvents |
| <input type="checkbox"/> CCLP Chloroprene | <input type="checkbox"/> CST Styrene |
| <input type="checkbox"/> CCHM Chromates | <input type="checkbox"/> CTL Toluene |
| <input type="checkbox"/> COB Dichlorobenzene | <input type="checkbox"/> CTE Trichloroethane ("T. e") |
| <input type="checkbox"/> CEDB Ethylene dibromide (EDB) | <input type="checkbox"/> CTEL Trichloroethylene |
| <input type="checkbox"/> CHT Halothane | <input type="checkbox"/> CNS One of previous two; not sure which one. |
| <input type="checkbox"/> CISC Isocyanates, methylene diphenyl isocyanate (MDI), or toluene diisocyanate (TDI) | <input type="checkbox"/> CINI Trinitrotoluene (TNT) |
| <input type="checkbox"/> CTH Other (Write in) _____ | <input type="checkbox"/> CVC Vinyl chloride |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |

PROTECTIVE EQUIPMENT

(PEQ-) Do/Did you use protective equipment while on this job?
 (Y) Yes (S) Not Sure (N) No

(TPQ-) If yes, which of the following do/did you use? Check ALL that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> (A) apron | <input type="checkbox"/> (G) gloves | <input type="checkbox"/> S(u)it |
| <input type="checkbox"/> (E) ear plugs, muffs, or cranial helmet | <input type="checkbox"/> (R) respirator | <input type="checkbox"/> (O*)ther (Specify) _____ |
| <input type="checkbox"/> (F) face mask | <input type="checkbox"/> (S) safety glasses | _____ |

NHRC [11-6-84]

OCCUPATIONAL HEALTH CARE
 OCCUPATIONAL HISTORY
 CHRONOLOGICAL OCCUPATIONAL PROFILE

OCCHX
 COP

JOB #2

Now that you have completed a CHRONOLOGICAL OCCUPATIONAL PROFILE for your current job (or, if unemployed, for your last job), please fill out a CHRONOLOGICAL OCCUPATIONAL PROFILE for all jobs (including military service) that you had prior to that. Start with the job just before your current job or, if unemployed, your last job (this is JOB #2), and then work backwards to high school or age 18, whichever comes first.

OFFICE USE ONLY			
SOCIAL SECURITY NUMBER	TODAY'S DATE MONTH / DAY / YEAR	PROVIDER NO. 1 LAST NAME	PROVIDER NO. 2 LAST NAME
SITE OF ENCOUNTER (A) North Island	TYPE (X) Occupational History for Job Number 2 of _____ (OFFICE USE ONLY)	VISIT CLASSIFICATION (OFFICE USE ONLY) <input type="checkbox"/> (10) Reviewed <input type="checkbox"/> (11) Not Reviewed	

EMPLOYMENT STATUS

(NCE) Name of employer: _____ (CSC) City, State or Country: _____
 (TND) Type of industry: _____ (HPW) Average number of hours worked per week: _____
 (YS) Year started: 19 ____ (TNW) Total years worked there: _____
 (YL) Year left: 19 ____ (TMW) Total months worked there (if less than one year): _____
 (YJT) What was your job title? (List ALL if more than one job title.)
 1. _____
 2. _____
 3. _____
 4. _____

(DJ) Briefly describe the duties of your job for each job title listed above.
 1. _____
 2. _____
 3. _____
 4. _____

JOB-RELATED HEALTH PROBLEMS OR INJURIES

(JRH-) While on this job, did you have any job-related health problems or injuries?
 (Y*) Yes (S*) Not Sure (N) No
 If yes or not sure, briefly describe each problem or injury. DO NOT WRITE IN THIS BOX
 1. _____
 2. _____
 3. _____
 4. _____

(CJP-) If yes or not sure, did any of your co-workers have health problems or injuries while on this same job?
 (Y*) Yes (S*) Not Sure (N) No
 If your co-workers had health problems or injuries, briefly describe each problem or injury. DO NOT WRITE IN THIS BOX
 1. _____
 2. _____
 3. _____
 4. _____

NHRC [11-6-84]

OCCUPATIONAL HEALTH CARE
 OCCUPATIONAL HISTORY
 CHRONOLOGICAL OCCUPATIONAL PROFILE

OCCHX
 COP

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) (CONT.)

HEALTH HAZARDS

What known health hazards were present on this job? Check the appropriate boxes. Leave the boxes blank if the hazard was not present or if you are not sure that the hazard was present.

	(A) Check here if health hazard was present on the job.	(B) Also check here if you were in direct contact with it by breathing, touching, or other direct exposure.	Indicate how long you were directly or indirectly exposed to the health hazard. YEARS MONTHS (Use whole numbers; no ranges) (Use whole numbers; no ranges)
(KHF-) Fibrous glass (fiberglass)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHA-) Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHC-) Coal dust or rock dust	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHS-) Silica powder or sandblasting dust	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHD-) Other specific dusts (wood,talc,lime).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHR-) Respiratory or skin irritants.	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHCH-) Chemicals (acids,alkalis,solvents)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHM-) Metal fumes (from molten metal).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHW-) Welding fumes.	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHL-) Coal tar, pitch, asphalt	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHE-) Engine exhaust, grease, oils, fuel	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHH-) Heat (severe).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHLB-) Cold (severe).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHN-) Noise (loud)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHZ-) Non-ionizing radiation	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHX-) Ionizing radiation (Xrays,etc.).	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHV-) Vibration (vibrating tools,motors)	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHG-) General shop dust.	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KHP-) Pesticides, herbicides	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KH01-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KH02-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KH03-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
(KH04-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

(NPN) Check here if there were no health hazards on this job

If you did not check Chemicals in the question above, go to the section on PROTECTIVE EQUIPMENT on the next page.

OCCUPATIONAL HEALTH CARE
 OCCUPATIONAL HISTORY
 CHRONOLOGICAL OCCUPATIONAL PROFILE

OCCHX
 COP

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) (CONT.)

HEALTH HAZARDS (CONT.)

If you checked Chemicals in the previous question, which of the following chemicals were you exposed to, directly or indirectly? Check ALL that apply which you are sure you were exposed to.

- | | |
|---|---|
| <input type="checkbox"/> CACD Acids | <input type="checkbox"/> CKT Ketones |
| <input type="checkbox"/> CALC Alcohols (industrial) | <input type="checkbox"/> CLD Lead (inorganic) |
| <input type="checkbox"/> CALK Alkalis (caustics) | <input type="checkbox"/> CMS Manganese |
| <input type="checkbox"/> CAMM Ammonia | <input type="checkbox"/> CMR Mercury (inorganic) |
| <input type="checkbox"/> CBNZ Benzene | <input type="checkbox"/> CMT Methylene chloride |
| <input type="checkbox"/> CBRY Beryllium | <input type="checkbox"/> CNK Nickel (inorganic) |
| <input type="checkbox"/> CCDM Cadmium | <input type="checkbox"/> CP Perchloroethylene |
| <input type="checkbox"/> CCOX Calcium oxide (lime dust) | <input type="checkbox"/> CPN Phenol |
| <input type="checkbox"/> CCBM Carbon monoxide | <input type="checkbox"/> CPS Phosgene |
| <input type="checkbox"/> CCT Carbon tetrachloride | <input type="checkbox"/> CPBB Polybrominated Biphenyls (PBB's) |
| <input type="checkbox"/> CCM Chlorinated naphthalene | <input type="checkbox"/> CPEB Polychlorinated biphenyls (PCB's) |
| <input type="checkbox"/> CCLF Chloroform | <input type="checkbox"/> CSL Solvents |
| <input type="checkbox"/> CCLP Chloroprene | <input type="checkbox"/> CST Styrene |
| <input type="checkbox"/> CCHM Chromates | <input type="checkbox"/> CTL Toluene |
| <input type="checkbox"/> CDB Dichlorobenzene | <input type="checkbox"/> CTE Trichloroethane ("Trike") |
| <input type="checkbox"/> CEBB Ethylene dibromide (EDB) | <input type="checkbox"/> CTEL Trichloroethylene |
| <input type="checkbox"/> CHT Malothane | <input type="checkbox"/> CNS One of previous two; not sure which one. |
| <input type="checkbox"/> CISC Isocyanates, methylene diphenyl isocyanate (MDI), or toluene diisocyanate (TDI) | <input type="checkbox"/> CTNT Trinitrotoluene (TNT) |
| <input type="checkbox"/> CTH Other (Write in) _____ | <input type="checkbox"/> CVC Vinyl chloride |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |

PROTECTIVE EQUIPMENT

(PEQ-) Did you use protective equipment while on this job?

- (Y) Yes (S) Not Sure (N) No

(TPQ-) If yes, which of the following did you use? Check ALL that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> (A)pron | <input type="checkbox"/> (G)loves | <input type="checkbox"/> S(u)it |
| <input type="checkbox"/> (E)ar plugs, muffs, or cranial helmet | <input type="checkbox"/> (R)espirator | <input type="checkbox"/> (O*)ther (Specify) |
| <input type="checkbox"/> (F)ace mask | <input type="checkbox"/> (S)afety glasses | _____ |
| | | _____ |

NHRC [11-6-84]

**OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY
CHRONOLOGICAL OCCUPATIONAL PROFILE**

OCCHX
COP

JOB # _____

Now that you have completed a CHRONOLOGICAL OCCUPATIONAL PROFILE for your current job (or, if unemployed, for your last job), please fill out a CHRONOLOGICAL OCCUPATIONAL PROFILE for all jobs (including military service) that you had prior to that. Start with the job just before your current job or, if unemployed, your last job (this is JOB #2), and then work backwards to high school or age 18, whichever comes first.

OFFICE USE ONLY	
SOCIAL SECURITY NUMBER -----	TODAY'S DATE ____/____/____ MONTH DAY YEAR
PROVIDER NO. 1 -----	PROVIDER NO. 2 -----
SITE OF ENCOUNTER (A) North Island	TYPE (X) Occupational History for Job Number ____ of ____ (OFFICE USE ONLY)
LAST NAME -----	LAST NAME -----
VISIT CLASSIFICATION (OFFICE USE ONLY)	
<input type="checkbox"/> (10) Reviewed <input type="checkbox"/> (11) Not Reviewed	

EMPLOYMENT STATUS

(NCE) Name of employer: _____	(CSC) City, State or Country: _____
(TND) Type of industry: _____	(HPW) Average number of hours worked per week: _____
(YS) Year started: 19 ____	(TNW) Total years worked there: _____
(YL) Year left: 19 ____	(TMW) Total months worked there (if less than one year): _____
(YJT) What was your job title? (List ALL if more than one job title.)	1. _____
	2. _____
	3. _____
	4. _____
(5J) Briefly describe the duties of your job for each job title listed above.	
1. _____	
2. _____	
3. _____	
4. _____	

JOB-RELATED HEALTH PROBLEMS OR INJURIES

(JRH-) While on this job, did you have any job-related health problems or injuries?
 (Y*) Yes (S*) Not Sure (N) No

If yes or not sure, briefly describe each problem or injury. DO NOT WRITE IN THIS BOX

1. _____	_____ _____ _____ _____
2. _____	
3. _____	
4. _____	

(CJP-) If yes or not sure, did any of your co-workers have health problems or injuries while on this same job?
 (Y*) Yes (S*) Not Sure (N) No

If your co-workers had health problems or injuries, briefly describe each problem or injury. DO NOT WRITE IN THIS BOX

1. _____	_____ _____ _____ _____
2. _____	
3. _____	
4. _____	

NHRC [11-6-84]

OCCUPATIONAL HEALTH CARE
 OCCUPATIONAL HISTORY
 CHRONOLOGICAL OCCUPATIONAL PROFILE

OCCHX
 COP

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) (CONT.)

HEALTH HAZARDS

What known health hazards were present on this job? Check the appropriate boxes. Leave the boxes blank if the hazard was not present or if you are not sure that the hazard was present.

	(A) Check here if health hazard was present on the job.	(B) Also check here if you were in direct contact with it by breathing, touching, or other direct exposure.	Indicate how long you were directly or indirectly exposed to the health hazard. YEARS MONTHS (Use whole numbers; no ranges) (Use whole numbers; no ranges)	
(KHF-) Fibrous glass (fiberglass)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHA-) Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHC-) Coal dust or rock dust	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHS-) Silica powder or sandblasting dust	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHD-) Other specific dusts (wood,talc,lime).	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHR-) Respiratory or skin irritants.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHCN-) Chemicals (acids,alkalis,solvents)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHM-) Metal fumes (from molten metal).	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHW-) Welding fumes.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHI-) Coal tar, pitch, asphalt	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHE-) Engine exhaust, grease, oils, fuel	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHH-) Heat (severe).	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHLD-) Cold (severe).	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHN-) Noise (loud)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHZ-) Non-ionizing radiation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHX-) Ionizing radiation (Xrays,etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHV-) Vibration (vibrating tools,motors)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHG-) General shop dust.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KHP-) Pesticides, herbicides	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KH01-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KH02-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KH03-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(KH04-) Other (Write in) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

(NPH) Check here if there were No health hazards on this job

If you did not check Chemicals in the question above, go to the section on PROTECTIVE EQUIPMENT on the next page.

OCCUPATIONAL HEALTH CARE
 OCCUPATIONAL HISTORY
 CHRONOLOGICAL OCCUPATIONAL PROFILE

OCCHX
 COP

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) (CONT.)

HEALTH HAZARDS (CONT.)

If you checked Chemicals in the previous question, which of the following chemicals were you exposed to, directly or indirectly? Check ALL that apply which you are sure you were exposed to.

- | | |
|---|---|
| <input type="checkbox"/> CACC Acids | <input type="checkbox"/> CKT Ketones |
| <input type="checkbox"/> CALC Alcohols (industrial) | <input type="checkbox"/> LLD Lead (Inorganic) |
| <input type="checkbox"/> CALK Alkalis (caustics) | <input type="checkbox"/> CMS Manganese |
| <input type="checkbox"/> CAMM Ammonia | <input type="checkbox"/> CHR Mercury (inorganic) |
| <input type="checkbox"/> CBNZ Benzene | <input type="checkbox"/> CHT Methylene chloride |
| <input type="checkbox"/> CBRY Beryllium | <input type="checkbox"/> CNK Nickel (inorganic) |
| <input type="checkbox"/> CCD Cadmium | <input type="checkbox"/> CP Perchloroethylene |
| <input type="checkbox"/> CCOX Calcium oxide (lime dust) | <input type="checkbox"/> CPN Phenol |
| <input type="checkbox"/> CCBM Carbon monoxide | <input type="checkbox"/> CPS Phosgene |
| <input type="checkbox"/> CCT Carbon tetrachloride | <input type="checkbox"/> CPBB Polybrominated biphenyls (PBB's) |
| <input type="checkbox"/> CCN Chlorinated naphthalene | <input type="checkbox"/> CPCB Polychlorinated biphenyls (PCB's) |
| <input type="checkbox"/> CCLF Chloroform | <input type="checkbox"/> CSL Solvents |
| <input type="checkbox"/> CCLP Chloroprene | <input type="checkbox"/> CST Styrene |
| <input type="checkbox"/> CCHM Chromates | <input type="checkbox"/> CTL Toluene |
| <input type="checkbox"/> CDB Dichlorobenzene | <input type="checkbox"/> CTE Trichloroethane ("Trike") |
| <input type="checkbox"/> EFDR Ethylene dibromide (EDB) | <input type="checkbox"/> CTCL Trichloroethylene |
| <input type="checkbox"/> CHT Halothane | <input type="checkbox"/> CNS One of previous two; not sure which one. |
| <input type="checkbox"/> CISC Isocyanates, methylene diphenyl isocyanate (MDI), or toluene diisocyanate (TDI) | <input type="checkbox"/> CTNT Trinitrotoluene (TNT) |
| <input type="checkbox"/> CTH Other (Write in) _____ | <input type="checkbox"/> CVC Vinyl chloride |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |
| Other (Write in) _____ | Other (Write in) _____ |

PROTECTIVE EQUIPMENT

(PEQ-) Did you use protective equipment while on this job?

- (Y) Yes (S) Not Sure (N) No

(TPQ-) If yes, which of the following did you use? Check ALL that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> (A)pron | <input type="checkbox"/> (G)loves | <input type="checkbox"/> S(u)it |
| <input type="checkbox"/> (E)ar plugs, muffs, or cranial helmet | <input type="checkbox"/> (R)espirator | <input type="checkbox"/> (O*)ther (Specify) _____ |
| <input type="checkbox"/> (F)ace mask | <input type="checkbox"/> (S)afety glasses | _____ |

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REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER 95-2	2. GOVT ACCESSION NO. AD A154091	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) DEVELOPMENT OF MEDICAL AND OCCUPATIONAL HISTORY FORMS FOR THE NAVY OCCUPATIONAL HEALTH INFORMATION MANAGEMENT SYSTEM		5. TYPE OF REPORT & PERIOD COVERED Interim
		6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) J. C. Helmkamp, R.L. Cohen, D.M. Ramsey-Klee, K. E. Guidera, C.M. Bone		8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS Naval Health Research Center P. O. Box 85122 San Diego, CA 92138-9174		10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS M0933-PN.003-0001
11. CONTROLLING OFFICE NAME AND ADDRESS Naval Medical Research & Development Command Naval Medical Command, National Capital Region Bethesda, MD 20814		12. REPORT DATE January 1985
		13. NUMBER OF PAGES 33
14. MONITORING AGENCY NAME & ADDRESS (if different from Controlling Office) Commander, Naval Medical Command Department of the Navy Washington, DC 20372		15. SECURITY CLASS. (of this report) UNCLASSIFIED
		15a. DECLASSIFICATION/DOWNGRADING SCHEDULE
16. DISTRIBUTION STATEMENT (of this Report) Approved for public release; distribution unlimited		
17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report) Approved for public release; distribution unlimited		
18. SUPPLEMENTARY NOTES		
19. KEY WORDS (Continue on reverse side if necessary and identify by block number) Medical History Form Occupational History Form Environmental Work-related Non-work-related		
20. ABSTRACT (Continue on reverse side if necessary and identify by block number) This report describes the development of the medical and occupational history forms in support of the Navy Occupational Health Information Management System (NOHIMS). The forms are presented in detail and discussed in terms of their importance in a computerized medical information system. The use of these forms will provide a comprehensive summary of an individual's medical, employment and exposure history throughout his or her adult life.		

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S N 0102 LF-014-6601

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