5000 N. 26th Street, Suite 200
Lincoln, NE 68521
(402) 475-6656

Company Care

Medical History Questionnaire

Date _____ Name _____ SS# _____

Address _____ City/State _____ Zip _____

Phone _____ Date of Birth: _____ Age _____ Sex M F

Employer _____ Job Title _____

		Yes	No	Date
1	A. Birth defects			
	B. Head injury			
	C. Neck injury (whiplash)			
	D. Thyroid problems			
2	A. Defective vision			
	B. Color blindness			
	C. Injury to eye			
	D. Cataract			
	E. Glaucoma			
	F. Blind spots/double vision			
	G. Do you wear glasses/contacts?			
3	A. Ear infection (chronic)			
	B. Mastoid surgery			
	C. Loss of hearing			
	D. Ringing in ears			
	E. Use of hearing aid			
	F. Abnormal hearing test			
4	A. Allergies			
	B. Sinus trouble			
	C. Hay fever			
	D. Frequent colds/sore throats			
	E. Difficulty swallowing			
	F. Frequent hoarseness			
	G. Frequent nosebleeds			
	H. Change in sense of smell			
	I. Change In sense of taste			
5	A. Tuberculosis			
	B. Chest surgery			
	C. Asthma			
	D. Lung collapse			
	E. Breast surgery			
	F. Shortness of breath			
	G. Chronic cough			
	H. Chest pain/pressure			
	I. Emphysema			
	J. Bronchitis			
	K. Night sweats			
6	A. High blood pressure			
	B. Heart murmur			
	C. Enlarged heart			
	D. Heart disease/failure			
	E. Rheumatic fever			
	F. Heart palpitations			
	G. Heart attack			
	H. Heart medication			
	I. Abnormal EKG			
7	A. Varicose veins			
	B. Stroke			
	C. Leg ulcers			
	D. Swelling of ankles			
	E. Leg pain on walking			
	F. Circulation problems			

		Yes	No	Date
8	A. Frequent backaches			
	B. Back surgery			
	C. Disc disease			
	D. Back injury or strain			
	E. Back x-rays			
	F. Chiropractic treatments			
	G. Arthritis			
	H. Rheumatism			
	I. Swollen joints			
	J. Polio			
	K. Amputations			
	L. Broken bones			
	Type			
	M. Dislocations			
	N. Painful feet			
	O. Rheumatoid arthritis			
	P. Surgically replaced joint			
	Q. Arm/wrist problems			
	R. Neck/shoulder problems			
	S. Knee/ankle problems			
	T. Carpal tunnel			
9	A. Ulcers			
	B. Colitis			
	C. Diarrhea (frequent)			
	D. Stomach problems			
	E. Vomiting blood			
	F. Bloody stools			
	G. Hepatitis			
	H. Cirrhosis			
	I. Yellow jaundice			
	J. Gallbladder trouble			
	K. Gall stones			
	L. Unrepaired hernia			
	M. Repaired hernia			
	N. Unexplained weight loss			
	O. Frequent vomiting			
	P. Loss/change of appetite			
	Q. Change in bowel habit			
10	A. Epilepsy/seizures			
	B. Fainting spells			
	C. Loss of consciousness			
	D. Dizziness or vertigo			
	E. Frequent exhaustion			
	F. Trouble with nerves			
	G. Frequent worry/depression			
	H. Difficulty with speech			
	I. Loss of coordination			
	J. Severe/migraine headaches			
11	A. Kidney trouble/stones			
	B. Bladder trouble			
	C. Kidney/bladder surgery			
	D.Change in bladder habits			
	E. Blood in urine			
	F. Prostate problems			

PATIENT NAME: _____ **DATE OF BIRTH:**_____

		Yes	No	Date
12	A. Anemia			
	B. Leukemia			
	C. Other blood diseases			
13	A. Diabetes			
	B. Pituitary problems			
	C. Cancer or tumors			
	Type:			
14	A. Alcohol _____ oz per week			
	B. Coffee/Tea ____ cups/day			
	C. Smoking ____ cig/day			
	____ # yrs smoked ___ yr quit			

		Yes	No	Date
15	A. Skin allergies (rash, hives)			
	B. Skin problems (dermatitis)			
	C. Sensitivity to chemicals			
	D. Reaction to medicines			
	E. Eczema/psoriasis			
	F. Cracked/thickened skin			
16	A. Painful menstruation			
	B. Hysterectomy			
	C. Are you pregnant?			

FAMILY HISTORY

Father: Living _____ if dead, cause of death _____ Brothers: Living ____ if dead, cause of death _____

Mother: Living _____ if dead, cause of death _____ Sisters: Living _____ if dead, cause of death _____

Has any member of the family had any of the following:Tuberculosis ___ Yes ___ No Cancer ___ Yes ___ No Mental Illness ___ Yes ___ No

Heart Disease ___ Yes ___ No Kidney Disease ___ Yes ___ No Arthritis ___ Yes ___ No

PRIOR HISTORY

Type of Surgery/Reason for Hospitalization	Year	Name and location of Surgeon/Hospital	Complications, if Any
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any serious injuries? Yes No

Do you currently have any prescriptions for drugs or medications? Yes No

List all the medications and herbal supplements you are now taking:

_____

List over the counter medications you are now taking:

_____

ALLERGY HISTORY

1. Do you have any allergies to medications? Yes No

2. Do you have any other allergies? Yes No

3. Do you have any food allergies, particularly bananas, avocados, kiwi, chestnuts, tomatoes, potatoes, broccoli? (please circle) Yes No

4. Do you have any history of swelling, itching or rash from contact with balloons or following dental, vaginal/rectal exams or surgery? Yes No

5. Have you ever had a reaction to latex products? (Band-Aids, rubber bands, etc.)? Yes No

If "yes" to any of the above, please explain _____

If "yes" is answered to questions 3-5, check with the receptionist regarding completion of the Latex Sensitivity Checklist

OCCUPATIONAL HISTORY

Do you now or have you ever suffered from back aches? Yes No

Have you ever taken medications for back aches or pain? Yes No

Do you suffer from pains going down the back of your leg? Yes No

Do you have back problems that require you to take time off from work? Yes No

Have you fractured/broken any bones in your hand or wrist? Yes No

Have you had any history of chronic pain in the upper extremities? Yes No

Have you ever experienced numbness in your hands? Yes No

Do you ever wake up in the middle of the night with pain or numbness in your hands? Yes No

Have you any history of tendonitis about the wrist or base of the thumb? Yes No

List permanent restrictions, if any (i.e. lifting limits)

_____

Have you ever cut your hand or wrist, tendon, nerves? Yes No

Have you ever worked with asbestos? Yes No

Have you ever worked with radioactive substances? Yes No

Have you ever had a skin rash or condition from any chemicals, plastics, solvents or metals? Yes No

Have you ever been poisoned or injured by chemicals, gases, fumes or metals? Yes No

Are you currently or have you ever been treated for a work related illness or injury? Yes No

Have you ever had a work related or other injury which resulted in one or more days off from work? Yes No

Have you ever had a work related or other injury which resulted in any work restrictions/light duty? Yes No

Please circle any of the following items you have been exposed to:

Welding	Repetitive Motion Work	Asbestos	Heavy metals
Dusty Environment	Excessive Noise	Silica	Toxic Chemicals
Soldering	Engine Exhaust	Foam Blowing	Pesticides
Radioactive Substances	Other _____		

I hereby attest that the above information is accurate. _____ Reviewed by _____