NorthShore
University HealthSystem

Health History

PLEASE PRINT

Last Name:	First Name:	Middle Name:	Date:

Street Address:	City:	State:	Zip Code:	Home Phone: ( )

Date of Birth:	Age:	Marital Status: M S W D	Sex: M / F	Social Security Number - -

Personal Physician:	Phone: ( )	City

Date of Last Complete Physical Exam:	Date of Last Tetanus Booster:	Company Name/Phone:

Department & Your Job:	Extension:	Supervisor:	Type of Exam:

This is a very extensive health history. The information you give about areas of your health which DO NOT RELATE TO YOUR JOB, or the JOB YOU ARE APPLYING FOR ARE **STRICTLY CONFIDENTIAL**. Please answer all the questions. When you answer yes, please give details.

Thank you for your cooperation.

Please List All:

Medications: _____

_____

Allergies: _____

Family History:	Mother	Father	Siblings
Age if Alive:			
Age at Death:			

Family History: Have your Parents or Siblings ever had?	Yes	No	**If "Yes" Give brief details**
Allergies			
Anemia			
Cancer			
Diabetes			
Alcohol / Drug Problems			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Liver Disease			
Lung Problems			
Neurologic Disorders			
Psychiatric Problems			
TB			
Inherited Disease			
Other Diseases			
Health History Continued:			
Have You Had Any Surgeries / Operations:	Yes	No	**If "Yes" Give brief details**
On Your Back, Arm, Leg, or Knee			
To Treat A Hernia			
To Treat Varicose Veins			

Any "OTHER" Operations			
HAVE YOU EVER BEEN HOSPITALIZED?			
Have You Ever Had or Do You Currently Have:			
Serious Allergy			
Bad Reaction to Any Medications			
Advised Not To Take Any Medication (i.e Aspirin)			
Skin – Have You Ever Had or Do You Currently Have:			
Hives / Eczema or Rash			
Chronic Skin Problems (i.e. Cuts slow to heal)			
Excessive Skin Dryness			
Problems With "Easy" Burning			
Chemical Or Jewelry Rash / Sensitivity			
Neuro – Have You Ever Had or Do you Currently Have:			
A Psychiatric or Emotional Problem			
Numbness / Weakness / or Paralysis			
Dizziness or Fainting Spells			
Severe / Frequent or Migraine Headaches			
Head Injury, Concussion, or Skull Fracture			
Neurological Disorders			
Seizures or Blackouts			
Stroke			
Ear / Eye - Have You Ever Had or Do you Currently Have:			
Hearing Loss			
Frequent Ear Infections			
Ringing in Ears			
Other Ear Problems			
Glaucoma or Cataracts			
Red Eyes			
Eye Injury / Vision Loss			
Other Eye Problems			
Other Eye Problems i.e. Strain From VDT Use			
Glasses / Contacts			
Date of Last Vision Screen:			
Head / Neck - Have You Ever Had or Do you Currently Have:			
Date of Last Dental Exam:			
Recent Problems with Teeth / Dentures			
Frequent Mouth Ulcers / Infections			
Sinus or Hay Fever			
Frequent Sore Throats or Strep Throat			
Frequent Nose Bleeds			
Trouble with Thyroid i.e. Taking Thyroid Meds			
Problem Requiring Radiation Treatment to the Neck Area			
Lungs - Have You Ever Had or Do you Currently Have:			
Asthma or Wheezing			
Coughed Up Any Blood			
Bothered by Shortness of Breath without Apparent Reason			
TB or A Positive Skin Test for TB			
Pneumonia or Pleurisy			
Do You Cough Every Day, Especially in the Morning			
Pain or Tightness in Chest			
Health History Continued:			
Lungs (Continued)	**Yes**	**No**	**If "YES" Give Details**
More Than Three Episodes of Bronchitis in One Year			
Ever Smoked – Tobacco or Any Form			How Long: Yrs Packs per Day: When Quit:

Had a Chest X-Ray			Last Time:
Heart - Have You Ever Had or Do you Currently Have:			
Rheumatic Fever or Heart Murmur			
Heart Disease			
Treated for Heart Condition			
Unusually Cold or Blush – Colored Hands or Feet			
High Blood Pressure – If "Yes" How is it treated			☐ Medicine ☐ Diet ☐ Exercise:
Do You Have A History of Elevated Cholesterol			
Anemia or Any Blood Disease			
Phlebitis, Varicose Veins or Blood Clots/Poor Circulation			
Chest Pain with Activity			
G.I - Have You Ever Had or Do you Currently Have:			
Ulcers			
Hiatal Hernia			
Indigestion, Pain, or Unusual Burning in Stomach			
Vomiting of Blood			
Bloody / Tarry Bowel Movement			
Infectious Diarrhea (e.g. Salmonella)			
Frequent Loose Bowel Movements			
Colitis or Nervous Stomach			
Yellow Jaundice or Hepatitis			
Problems with Your Pancreas			
Gallbladder Disease			
Kidneys - Have You Ever Had or Do you Currently Have:			
Bladder or Kidney Infections			
Kidney Stones			
Burning or Discomfort on Urination or Frequent Urination			
Hernia			
Blood in Urine			
Miscellaneous - Have You Ever Had or Do you Currently Have:			
Diabetes or Sugar in Your Blood or Urine			
Cancer of Any Kind			
Musculo – Skeletal - Have You Ever Had or Do you Currently Have:			
Arthritis, Rheumatism Neck, Back, or Spine Injury of Disease			
Been Treated for A Back Problem			
Recurrent Stiffness of Back Pain			
Bursitis Tendonitis			
Recurrent Pulled Muscles or Sprains			
Hand or Wrist Injury or Problem			
Elbow or Shoulder Injury or Problem			
Hip or Knee Injury or Problem			
Ankle or Foot Injury or Problem			
Frost Bite			
Job Requiring Heavy Lifting or Standing, or Sitting for Long Periods of Time			
Any Broken Bones			
FOR FEMALES ONLY - Have You Ever Had or Do you Currently Have:			
Menstrual Irregularities			
Recurrent Problems of the Female Organs			
Breast Masses or Lumps			
Do You Practice Monthly Breast Self Exam			
Health History Continued:			
FEMALES ONLY (Continued)	**Yes**	**No**	If "Yes" Give Details
Have You Ever Had A Mammogram			
Date of Last Pap Smear:			
FOR MEN ONLY - Have You Ever Had or Do you Currently Have:			

Prostate or Testicular Problems			
Breast Tenderness, Swelling, or Lumps			
Do You Practice Monthly Testicular Self Exam			
General Lifestyle I: Check The Answer That Best Describes You			
General Health	☐ Poor ☐ Fair ☐ Good ☐ Excellent		
% Seatbelt Use	☐ 0-24% ☐25-49% ☐ 50-75% ☐ 75-100%		
Daily Stress	☐ Low ☐ Moderate ☐ High		
Average Hours of Sleep	☐ 6 hrs or less ☐ 7-8 hrs ☐ 8 hrs or more		
Average Meals daily	☐ 1 Meal ☐ 2 Meals ☐ 3 or more		
Average of Eggs per Week	☐ 0-1 ☐ 2 ☐ 3 or more		
Average Number of Red Meat Meal per Week	☐ 0-1 ☐ 2-3 ☐ 4 or more		
Average Number of Alcohol Beverages/Beers per Week	☐ 0-5 ☐ 6-14 ☐15 or more		
	Yes	No	If "Yes" Give Details
Do You Exercise 3 times per Week? 30-40 Min Each Time? Identify Types of Exercises			
Are You More Than 30% Above Your Ideal Weight?			
Have You Received A Tetanus Booster in the Last 10 Years?			
Have You Been Immunized Against Hepatitis B?			Year Immunized:
Do You Take Any Prescription Medication?			
Do You Take Non-Prescription Medication (Or "Over The Counter") Drugs on a Regular Basis?			
General Lifestyle II:			
Do you Participate in a Workplace Wellness / Health Promotion Program?			
Which of the Following Would you like to See Offered and Would you Participate in?			
Cholesterol Screen			
Blood Pressure Screen			
Weight Loss			
Nutrition Program			
Stress Management			
Smoking Cessation			
CPR			
Blood Drive			
Health Risk Appraisal			
Self Directed Exercises			
Health Education Program			
Women's Health			
Work History I. Have You Ever:			
Been Restricted in your Work or Given "Light Duty" because of your Health or Injury?			
Left a Job because of Health Problems			
Been Injured on the Job and Treated by a Doctor			
Received Compensation for an Industrial Injury or Illness			
Are you Receiving any Health Care Treatment (i.e. Physician Therapy, Chiropractic, Acupuncture, Medical, etc?)			
Been Hospitalized in the last Five Years			
Have you had any Illness or Injury that we have not asked you about?			
Work History II.			
Do you have Hobbies such as Furniture Refinishing, Painting, Hunting, Shooting, or Model Building?			
Do you Moonlight or have a Second Job?			
Health History Continued	**Yes**	**No**	If "Yes" Give Details, Dates, and Number of Years. Give Time Exposed (Hours/Days and Number of Years) – Any Protection
Work History III. Exposures – Have You Ever Worked In or Around A:			
Chemical Plant			
Chemistry Laboratory			

Coke Oven			
Construction			
Cotton, Flax, or Hemp Mill			
Electronics Plant			
Farm			
Foundry			
Hazardous Waste Industry			
Hospital			
Lumber Mill			
Metal Production			
Mine			
Nuclear Industry			
Paper Mill			
Pharmaceutical			
Plastic Production			
Pottery Mill			
Refinery			
Rubber Processing Plant			
Sand Pit or Quarry			
Service Station			
Shipyard			
Smelter			
Waste Industry			
Have You Ever Worked With or Been Exposed To:			
Aldrin			
Arsenic			
Asbestos			
Benzene			
Benzidine			
Beryllium			
Bis Chlormetnyl Ether			
Cadmium			
Carbon Disulfide			
Carbon Tetrachloride			
Chlorine			
Chlorodane			
Chloroform			
Chloroprene			
Chromates			
Chromic Acid Mist			
Cutting Oils			
DDT			
Dieldrin			
Dioxin			
Dust Coal			
Dust Sandblasting			
Dust Other			
Epoxy Resin			
Ethylene Dibromide			
Ethylene Oxide			
Extreme Heat or Cold			
Heptachlor			
Hexacholoropenzene			
Isocyanates (TDI, MDI			

Health History Continued	**Yes**	**No**	If "Yes" Give Details, Dates, and Number of Years. Give Time Exposed (Hours/Days and Number of Years) – Any Protection
Have You Ever Worked or Been Exposed to (Continued):			
Loud or Continuous Noise			
Mercury			

Methyylene Choride			
Microwaves, Lasers			
Nickel			
PCB's			
Pesticides, Herbicides			
Phenois			
Phosgene			
Plastics			
Radioactive Materials			
Roofing Materials			
Rubber			
Silica			
Solvents / Degreasers			
Soots and Tars			
Spray Painting			
Tri / Per Chloroethylene			
Vinyl Chloride			

List Any Toxin / Chemicals / Biological Hazards You May Currently Be Exposed To: _____

_____

_____

Work History IV: Jobs – Start with Most Recent			
Date (Year to Year)	Company	Position	Any Work Hazards

I certify that the above information is true and complete to the best of my knowledge.

Date: _____ Signature: _____

Examiner: _____