FIRELANDSHEALTH
Firelands Regional Medical Center

Corporate Health Center
5420 Milan Rd.
Sandusky, OH 44870
419-557-5052

Patient Name _____ DOB _____

Patient History Form

Have you ever had or do you currently have any of these conditions?

☐ Select All "No"
☐ Reset Form

	Yes	No		Yes	No
Anxiety			Head Injury		
Bipolar			Hearing or Ear Problems		
Depression			Migraines		
Drug or Alcohol Abuse			Seasonal Allergies/Hay Fever		
Other Mental Health Conditions			Sinus Problems		
			Vision or Eye Problems		
Asthma					
Chronic Bronchitis/COPD					
Chronic Cough			Indigestion/Reflux		
Sleep Apnea			Inflammatory Bowel Disease		
			Liver Disease		
			Stomach Ulcers		
Arthritis					
Back or Neck Problems					
Bone or Joint Deformity			Hernia		
Broken Bones			Kidney Disease		
Muscular Disease			Kidney Stones		
Rheumatoid Condition					
Spine Injury					
			Anemia or Blood Disorders		
			Cancer or Tumors		
Heart Arrhythmia or Murmur			Diabetes		
Heart Attack or Heart Disease			Thyroid Disease		
High Blood Pressure			Neurological Condition		
Other Heart Conditions			Epilepsy/Seizures		
			Stroke/TIA		
			Skin Disorders/Rashes		

If yes to any of the above, please explain below

Explanation of medical conditions and any additional conditions not listed above:

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Do you wear: Glasses ☐ Contacts ☐ Hearing Aids ☐ Prosthetic ☐ Other Devices ☐

How often do you consume alcohol? Daily ☐ Weekly ☐ Occasionally ☐ Never ☐

Have you ever smoked, vaped, or chewed? Yes ☐ No ☐

	Age Started	**Age Stopped (leave blank if still using)**	**How Much Per Day?**
Cigarettes			
Cigars			
Vaping			
Chew			

Who is your Primary Care Provider? _____

List any previous surgeries or overnight hospital stays and dates if known:

List all medications including prescription, over the counter, and supplements:

List your allergies and reactions (if known) to drugs, foods, etc.:

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Have you had any substantial exposures to the substances listed below?

☐ *Section does not apply for current job description (school/nursing home/hospital, etc.)*

Please mark the number of years exposed.

	None	1 Year	1-5 Years	> 5 Years
Noise (guns, machines, loud music, etc.)	✔			
Household or Agricultural Chemicals (pesticides)	✔			
Radiation, radioactive materials, x-rays	✔			
Metal, fumes, or dust (ie: welding)	✔			
Other dusts (ie: silica, asbestos, lime)	✔			
Paints and dyes	✔			
Solvents (cleaning, degreasing, thinning)	✔			
Petroleum Products (oils, lubricants)	✔			
Chemicals (adhesives, plastics, rubber)	✔			
Smoke (exhaust, fumes)	✔			
Vibration (tools, guns)	✔			
Other:	✔			

Are you right hand or left hand dominant? Right ☐ Left ☐

Is there any medical or occupational history that was not covered on this form that you would like us to know about? Please list below:

I certify that the information provided in this form is true and completed to the best of my ability. I understand that withholding medical information may result in adverse health conditions as the Providers of Firelands Corporate Health Center are unable to appropriately evaluate and compare historical data to my potential occupational environment.

Employee Signature *See attached medical history supplemental form* Date _____

Reviewed by: _____ Date _____