

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

Patient Name		DOB	
	Patient History Form		

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		

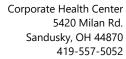
If yes to any of the above, please explain below
Explanation of medical conditions and any additional
conditions not listed above:



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

									,,,5
Do you	wear:	Glasses	Contacts	Hea	ring Aids	Pro	sthetic	Other D	evices (
How of	ten do	you consu	ıme alcohol?	Daily	Weel	cly	Occasion	ally	Never
Have yo	ou ever	smoked,	vaped, or ch	ewed?	Yes N	10			
			Age Sta	arted	_	e Stop ank if	ped still using)	How	Much Per Day?
	Ci	garettes							
		Cigars							
		Vaping							
		Chew							
Who is your Primary Care Provider? List any previous surgeries or overnight hospital stays and dates if known:									
List all I	medica [.]	tions inclu	ding prescrip	tion, o	ver the cou	inter, i	and suppler	ments:	

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





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 _					