111 Michigan Avenue, NW
Washington, DC 20010
Office (202) 476-2035
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Employee /Volunteer Medical History

Occupational Health

Biennial Update

Please print.

Name (Last, First, Middle):	Email Address:	DOB:
Address:		SSN:
	Telephone (Work):	Marital Status:
Department:	Position:	Employee ID #:
Under care of physician? ☐Yes ☐ No	If yes, for what?	
Physician's Name:	Physician's Address:	
Present Disability, If any:		

Medical History Update

Please check box for illness (es) that occurred since last visit only.

	Yes	No		Yes	No		Yes	No
Measles (Rubeola)	☐	☐	Back Trouble	☐	☐	Seizures	☐	☐
Measles (Rubella)	☐	☐	Eczema	☐	☐	Asthma	☐	☐
Mumps	☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐
Chickenpox	☐	☐	Pneumonia	☐	☐	Allergies	☐	☐
Whooping Cough	☐	☐	Kidney Disease	☐	☐	Hepatitis	☐	☐
Scarlet Fever	☐	☐	Venereal Disease	☐	☐	Herpes	☐	☐
Tuberculosis	☐	☐	Typhoid Fever	☐	☐	Hypertension	☐	☐
Arthritis	☐	☐	Anemia	☐	☐			
TB Assessment:			Sweats at night?	☐	☐	Chronic cough with mucus?	☐	☐
Unexplained fever for more than 1 week?	☐	☐	Unexplained weight loss?	☐	☐	Unexplained chest pain with breathing?	☐	☐

Operations since last visit to Occupational Health? ☐ Yes ☐ No

If "YES", please give details: ______________________

Female Employees:

Last Menstrual Period Date: __________

☐ Painful ☐ Irregular ☐ Regular

Pregnancies: _______ Children: _______

Have you ever been injured at work? ☐ Yes ☐ No If "YES", please give details: ______________________

Have you ever been or are you currently being treated for mental problems or nervousness? ☐ Yes ☐No

Have you ever been a patient in a mental hospital? ☐ Yes ☐ No

Immunization Dates (Year):

Diphtheria: _______ Tetanus: _______ Smallpox: _______ T.B Skin Test Date: _______ Result: ☐No ☐ Pos Polio: _______ MMR: _______

Do You Use:

Tobacco: ☐ Yes /No Alcohol: ☐ Yes/No

Are you taking any medications? ☐Yes ☐ No

List:

Tested for Color Blindness? ☐ Yes ☐ No

Are you Color Blind? ☐ Yes ☐ No

Emergency Contact

Name:				Relationship:
Address:	City:	State:	Zip:	Phone:

I CERTIFY THAT THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT ANY DELIBERATE WITHHOLDING OF SIGNIFIANT HEALTH INFORMATION MAY RESULT IN MY DISMISSAL.

Signature   Date