Olathe HEALTH
Occupational Wellness

Occupational Health
Employee Health Questionnaire

Visit Information

Appointment Date:	Appointment Time: ☐am ☐pm	No Show: ☐ No ☐ Yes
Check-In Time: ☐am ☐pm	Visit Start Time: ☐am ☐pm	Visit Discharge Time: ☐am ☐pm

Employee Information

First Name:	MI:	Last Name:
Birthdate:	Age:	Gender: ☐ M ☐ F
Height:	Weight:	Occupation:

Company Information

Employer Name:

Self-Assessment

Do you have any current disabilities requiring restricted activity? Yes ____ No_____

If yes, date of disability: ________________________ State: _________

If yes, restriction is: ___ Permanent ___ Temporary If Temporary, until what date? _________________________

What work will you be doing? ____

Have you done this type of work before? Yes ____ No _____

If so, did you have problems? Yes ____ No _____

Do you feel you can physically do this job? Yes ____ No _____

Have you ever had or been treated for any of the following?

	Yes	No		Yes	No
Convulsions, seizures, epilepsy			Asthma or wheezing		
Concussion or head injury			Emphysema or COPD		
Disabling headaches			Positive test for tuberculosis		
Dizziness or vertigo			Shortness of breath		
Fainting or unconsciousness			Cough lasting more than 2 months		
Color Vision problems			Other lung disease or surgery		
Eye disease or injury			Liver disease or hepatitis		
Hearing loss, difficulty hearing			Unusual bleeding		
Ear disease or injury			Kidney disease		
Chest pain			Protein/blood/sugar in urine		
Heart Attack			Other sleep disorder		
Abnormal heart rhythm			Diabetes		
Cardiac stents or angioplasty			Anemia or blood disorder		
Other heart problem or disease			Chronic skin rash or disease		
Heart Surgery			Cancer		
High blood pressure			Numbness or Tingling		

Muscle weakness			Herniated disc or sciatica		
Depression or anxiety			Other mental illness		
Any other illness or condition			Other		

Please explain the details of all yes answers above: ____

____

Have you ever had an injury to or problems with?

	Yes	No	Explanations for Yes answers
Back			
Neck			
Shoulder			
Elbow			
Arm/Wrist/hand			
Hip/Thigh/leg			
Knee			
Ankle/foot			
Other			

Have you ever had surgery? Yes ____ No _____ If Yes, then please provide in descending order:

Type of Surgery	Year	Medical Facility	Complications, if any:

Please list your 5 most recent jobs in descending order:

Job Title	Year Range	**Exposures** (i.e. Asbestos, Solvents, Pesticides, Coal, Cotton Dust, Epoxy Resins, Heavy Metals or Mining, Foundry Work, Fumes/Vapors, Silica, Pesticides, Solvents/Degreasers, Welding/Soldering, Other Chemicals/Hazards, etc.)

Please provide your medication history, including prescriptions, over the counter medications, supplements, vitamins, and inhalers:

Olathe HEALTH
Occupational Wellness

Occupational Health
Employee Health Questionnaire

List medication allergies: ____

____

Please answer the following questions:

Have you ever been off work for more than seven (7) days due to a job-related illness or injury? Yes _____ No _____

Have you ever resigned, been terminated or changed jobs for medical reasons? Yes ______ No _____

Are you allergic to latex? Yes ______ No _____

Are you allergic to any food, chemicals, metals, or insect stings? Yes _____ No _____

If Yes, please specify: ____

Do you use tobacco products? Yes _____ No _____

If Yes, please specific type: Cigarettes/Cigars/Chewing/Other: ____

If Yes, number of years: __________________

Recently Quit? Date: ____________________

Do you drink alcohol?

If Yes, please list _____ drinks per day and _____ number of times per week

Do you use illegal or recreational drugs?

If Yes, list: ___________________________

Do you have any physical or mental/emotional problems that would interfere with any of the following:

	Yes	No	Explanations for Yes Answers
Working in cold or heat			
Working around or operating machinery			
Driving a company vehicle			
Working in confined spaces			
Wearing/Using a respirator mask			
Working with soaps, detergents, or solvents			
Working at heights			
Managing multiple tasks			
Other: please list			

I hereby declare that, to the best of my knowledge, the information given above is correctly recorded, complete and true, and I understand that any falsification, misrepresentation or omission will cause me to be disqualified as an applicant or an employee. I hereby authorize this healthcare facility / provider to release medical information pertinent to this occupational health service.

Patient's Printed Name: ________________________________ Patient's Signature: ___________________________________

Patient: _________________________________ DOB: _____________________ Date of Service: _________________________