COLONIAL MEDCARE, P.C.
2801 BOULEVARD, SUITE B
COLONIAL HEIGHTS, VIRGINIA 23836
(804) 524-0524

MEDICAL AND/OR OCCUPATIONAL HISTORY

Name: _____ SS# _____ Chart# _____

DOB: _____ Personal Physician: _____

HISTORY: Have you ever had or do you now have any of the following (Check each item)

	Yes	No		Yes	No
Air, care, train or sea sickness	___	___	"Trick" or locked knee	___	___
Allergy	___	___	Loss of memory or amnesia	___	___
Anemia	___	___	Pneumonia	___	___
Arthritis or Rheumatism	___	___	Shortness of breath	___	___
Asthma	___	___	Mental Disease	___	___
Backache, back trouble	___	___	Chest air or pressure	___	___
Sciatica, herniated disc	___	___	Kidney or bladder trouble	___	___
Back Injury	___	___	Painful or bloody urination	___	___
Blood in sputum	___	___	Hemorrhoids or rectal disease	___	___
Bronchitis	___	___	Rapid Pulse	___	___
Cancer, tumor or cyst	___	___	Rheumatic fever	___	___
Impaired hearing or deafness	___	___	Skin disease or dermatitis	___	___
Deformity or lameness	___	___	Sinus Trouble	___	___
Depression	___	___	Stomach, liver, ulcer,		
Dislocation of joints	___	___	Intestinal problems	___	___
Dizziness or fainting spells	___	___	Swollen or painful joints	___	___
Diabetes	___	___	Eye problems	___	___
Drug reaction	___	___	Foot trouble or bad arches	___	___
Ear, nose, throat problems	___	___	Frequent or severe headaches	___	___
Epilepsy	___	___	Heart Trouble	___	___
Frequent colds	___	___	Hepatitis or liver problems	___	___
Hay Fever	___	___	High blood pressure	___	___
Gallbladder problems/gallstones	___	___	Treatment for alcohol use	___	___
Hernia or rupture	___	___	Drug addiction	___	___
Hives	___	___	Tendonitis	___	___
Alcoholism	___	___	Nervous Breakdown	___	___
Tuberculosis	___	___	Heel spurs, fallen arches	___	___
Varicose Veins	___	___	Recent gain or loss in weight	___	___
Indigestion or heartburn	___	___			
Numbness/tingling in hands	___	___			

Other: _____
Comments: _____

Date of last tetanus immunization: _____ Dominant hand: _____ Right _____ Left

Have you ever:

	YES	NO
Been a patient in a hospital or institution	___	___
Been declared fully or partially disabled	___	___
Been in a branch of military service	___	___
Been medically discharged from the military service	___	___
Had any type of surgery (Inpatient/outpatient)	___	___

If so, explain: _____
_____
_____

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OCCUPATIONAL HISTORY:

1. Are you working on the same type of job this year as you were last year?

   Yes _____ No _____

2. What chemicals are you exposed to you on the job?

   _____

   _____

   _____

3. How many hours per day are you exposed to chemicals? _____

4. Have you noticed any skin rash within the past year you feel was related to your work?

   Yes _____ No _____

   If so, explain the circumstances: _____

5. Have you noticed that any chemical makes you cough, have shortness of breath or wheeze?

   Yes _____ No _____

   If yes, can you identify it?_____

6. Have you ever had to leave or significantly modify your employment for health reasons?

   Yes _____ No _____

7. Have you ever worked in a noise hazardous environment?

   Yes _____ No _____

8. Have you ever been classified as a radiation worker?

   Yes _____ No _____

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MISCELLANEOUS

1. Do you smoke? Yes _____ No _____

   If so, how much and for how long? _____

   Pipe: Number/Day_____ Years

   Cigars: Number/Day_____ Years

   Cigarettes: Number/Day_____ Years

   If you do not smoke, did you smoke in the past? Yes _____ No _____

   If so, how much and for how long? _____

   When did you quit smoking (year)?_____

2. Do you drink alcohol in any form? Yes _____ No _____

   If so, how much and how often? _____

3. Do you wear glasses or contact lenses? _____

4. Do you get any physical exercise other than that required doing your job?

   Yes _____ No _____

5. Do you have any hobbies or "side jobs" that require you to use chemicals, such as woodworking, Sandblasting, insulation, painting, auto bodywork, etc?

   Yes _____ No _____

   If so, please describe, giving the type of business or hobby, chemicals used, how often used, etc.

   _____

   _____

   _____

   _____ _____

   Patient Signature Date