

PATIENT HISTORY FORM
Sparrow Health System – Occupational Health Services

Name:		Social Security #:		Birthdate:	
Address:			City:		State:
			Zip:		Age:
Home phone #: () -		Sex: M F		Height:	
Work phone #: () -				Weight:	
				Marital status (circle one) S M Sep D W	
Next of kin not living with you:				Phone #:	
History of past or present condition – check only if applicable					
<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Stomach trouble	<input type="checkbox"/> Fainting spells		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hernia	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Fractures		
<input type="checkbox"/> Back injuries	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Head injuries		
<input type="checkbox"/> Blood diseases	<input type="checkbox"/> Emotional disease	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rheumatic fever		
<input type="checkbox"/> Chronic back pain	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Mental disease	<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Operations	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Skin disease		
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Injuries	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Hospitalization		
Explain above checked condition(s), give dates:					
Describe any other medical problems:					
History of neck, back, shoulder, knee problems: <input type="checkbox"/> Yes <input type="checkbox"/> No					
History of surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No					
History of carpal tunnel problems (numbness, tingling of the hands): <input type="checkbox"/> Yes <input type="checkbox"/> No					
History of hernia problems: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you take any prescription drugs on a regular basis? <input type="checkbox"/> YES <input type="checkbox"/> NO List:					
Are you allergic to any medications? <input type="checkbox"/> YES <input type="checkbox"/> NO List:					
Do you smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO How much? _____ How long? _____					
Are you an ex-smoker? <input type="checkbox"/> YES <input type="checkbox"/> NO When did you quit? _____					
When was your last tetanus shot? _____					
Who is your family physician? _____					
Have you ever or are you now collecting sickness/accident or workers comp? Explain:					
Employment History:					
		<u>Employer</u>	<u>Dates</u>	<u>Job Description</u>	
1.					
2.					
3.					

The following to be signed by the applicant: I the undersigned, hereby certify that all the information I have furnished on this form is true and correct. I willingly submit to any required tests necessary to complete this examination.

Applicant signature: _____ Date: _____