Health History Questionnaire 2023-2024

This form is used as an evaluation tool to determine what the health status and needs are among workers of Troy Regional Medical Center. This information is CONFIDENTIAL and will be secured in your employee health file. **PLEASE COMPLETE ALL BLANKS**

Name____ Male or Female

Address____

Phone # __________________ Date of Birth___________

Department:__________________________ Job Title:________________________

Family History: Nervous or Mental Illness _______ Diabetes _______ Tuberculosis _________
Your personal health is : Excellent________ Good ________ Fair ________ Poor _________

	YES	NO		YES	NO
Do you have Diabetes?	_____	______	On Special Diet ?	_____	______
Do you have High Cholesterol?	_____	______	On Special Diet ?	_____	______
Do you have High B/P?	_____	______	On Special Diet ?	_____	______

PRESENT MEDICATIONS: **REASON:**

1.____

2.____

3.____

Have you ever had or been Vaccinated for:
(Either as child or adult)

	YES	NO
Chickenpox (Varicella-Zoster)	___	___
Measles	___	___
Mumps	___	___
Rubella (3 day Measles)	___	___
Hepatitis B	___	___
COVID Vaccine	___	___

Physical Activity

Which of the following describes your activity level when Not at Work?

__ Active- An athlete in training or a person who exercises at a level comparable to running at least 2 miles/day, 5days/wk.

__Moderately Active- Planned physical activity at least 3 times/wk involved in yard work, gardening, farming, etc.

__Sedentary- Only normal daily activities, such as eating, sleeping, talking, or watching TV.

Do You wear seatbelts?
No ______ Sometimes ______ Always _______

Are you allergic to:

	YES	NO
Penicillin	___	___
Sulfa Drugs	___	___
Yeast	___	___
Eggs	___	___
Dust	___	___

Drinking History Re: Alcohol

	YES	NO
Never drink	___	___
1-4 drinks yearly	___	___
1-4 drinks monthly	___	___
1-4 drinks weekly	___	___
1-4 drinks daily	___	___

Smoking History:

Never smoked _____
Stopped smoking (# of years ago) ____
Smoke now (# of years) ____

Medical History **Check Appropriate Boxes.**

This information is NOT mandatory but helpful if answered.

Chest and Lungs	Past	Now	Never
Bronchitis	___	___	___
Emphysema	___	___	___
Pneumonia	___	___	___
Chronic Cough	___	___	___
Coughing up Blood	___	___	___
Asthma	___	___	___
Tuberculosis	___	___	___
Wheeze or gasp for breath?	___	___	___

Cardiovascular (Heart)	Past	Now	Never
Heart pain at Rest or Exertion	___	___	___
Fast or Irregular Pulse	___	___	___
\eart Attack or Abnormal EKG	___	___	___
Swollen Ankles or Varicose veins	___	___	___
Poor Circulation in Fingers or Toes	___	___	___
Palpitations or Heart Murmur	___	___	___
Other:	___	___	___

Neurology	Past	Now	Never
Severe or Migraine Headaches	___	___	___
Severe Dizziness or Fainting Spells	___	___	___
Paralysis or Numbness	___	___	___
Convulsions	___	___	___
Loss of Coordination	___	___	___
Other:	___	___	___

SKIN	Past	Now	Never
Hives	___	___	___
Exzema / Dermatitis	___	___	___
Frequent Cold Sores	___	___	___
Other:	___	___	___

NOSE	Past	Now	Never
Nosebleeds	___	___	___
Sinusitis	___	___	___
COVID positive	____	____	____

Throat	Past	Now	Never
Persistent or frequent Hoarseness	___	___	___

Bones and Joints	Past	Now	Never
Stiff Muscles/Joints not related to exercise	___	___	___
Gout/Bursitis/Arthritis	___	___	___
(Ruptured Disc)	___	___	___
Injury/Strain (Low Back)	___	___	___
Carpal Tunnel Syndrome	__	___	___

Stomach/Intestines	Past	Now	Never
Hernia	___	___	____
Loss of Appetite	___	___	____
Stomach Ulcer	___	___	____

Eyes	Past	Now	Never
Blurring of Vision	___	___	____
Double Vision	___	___	____
Cataracts	___	___	____
Glaucoma	___	___	____
Do you wear glasses or contacts?	__	___	____

Ears	Past	Now	Never
Ear Infection	___	___	____
Ringing in Ears	___	___	____
Hearing Loss	___	___	____

Blood System	Past	Now	Never
Leukemia	___	___	____
Immuno-compromise	___	___	____
Hemophilia	___	___	____

Do you Bruise easily? Yes__ No __

Do you see a doctor at least annually? Yes__ No __

List all other health conditions not already addressed: ____

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