Medix Occupational Health Services
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Assessment Questionnaire

Name (Last, First, Middle):				Today's Date:
Address:		City:	State, Zip Code:	E-mail:
Birthdate:	Age:	☐ Right Handed ☐ Left Handed	ID Number:	Home/Cell Phone ( )

Current Employment

1. Year of Hire:_____ *Have you ever left for more then 6 months* ☐ Yes_____ Months
2. Do you currently work at another job? ☐ Yes, Number of hours per week:_____
   Where:_____
3. Current primary assignment:_____

Tobacco and Alcohol

Smoking

4. Have you smoked at least 100 cigarettes (5 packs) in your entire life?
   ☐ Yes ☐ No ***go to Question 12***
5. About how many packs do you (or did you) usually smoke per day?_____
   If less then 1 per day, enter 01
6. For about how many years have you smoked (or did you smoke) this amount?_____
   If less than 1 year, enter 01
7. How often do you smoke now? ☐ Every day ☐ Some days ☐ Not at all
8. If you currently use ***any tobacco products***, what kind do you regularly use? *Mark all that apply.*
   ☐ Cigarettes ☐ Every day ☐ Some days ☐ Special Occasions
   ☐ Cigars ☐ Every Day ☐ Some Days ☐ Special Occasions
   ☐ Pipe ☐ Every Day ☐ Some Days ☐ Special Occasions
   ☐ Chew ☐ Every Day ☐ Some Days ☐ Special Occasions
   ☐ Do not currently use tobacco
9. During the past 12 months, have you stopped using tobacco for one day or longer because you were trying to quit? ☐ No ☐ Yes If yes, number of days you quit:_____
10. Were you enrolled in a tobacco cessation program this year? ☐ Yes ☐ No
11. If you used to smoke, and successfully quit, what year did you stop smoking?_____
    (Congratulations!)

Physician Initials ☐

Alcohol

12. During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor? ☐ Yes ☐ No ***if No, go to Question 15.***

13. During the past 30 days, how many days per week / or month did you have at least one drink of any alcoholic beverage? _____ days per week / or _____ days in past 30 days.

14. During the past 30 days, on the days when you drank, about how many drinks did you drink on average? _____ Number of drinks

Work Place Exposure

15. In the past year have you been exposed to any environmental factor(s) in the workplace that could cause impaired health that could be classified as chemical, physical, biological, or ergonomic?

If yes, when?	If yes, what?	What type of symptoms?

Your Health History

If you have previously been seen at Medix and if there is no change in your health history, please check here ☐ and skip down to Question 17.

16. Below is a list of health problems. Please indicate if and how recently you were diagnosed, and whether you are currently experiencing the problem.

Health Problem Diagnosed by a health professional	**Diagnosed**	**Currently Experience this Problem**	**Currently Taking Medication**	**Medications & (Dosages)**
Diabetes: Type:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Hypertension *high blood pressure*	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Hyperlipidemia high cholesterol, high triglycerides	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Cancer:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Heart Disease:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Respiratory Disease *asthma, emphysema, COPD, etc.*	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Gastrointestinal Disease *ulcer, acid reflux, colitis, etc.*	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Reproductive Health *dysfunction, fetal abnormality, etc.*	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Neurologic Disease *seizure disorder, stroke, etc.*	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)

Your Health History continues on next page

Your Health History, *continued*

Health Problem Diagnosed by a health professional	**Diagnosed**	**Currently Experience this Problem**	**Currently Taking Medication**	**Medications & (Dosages)**
Hepatitis: Type:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Allergies:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Psychiatic Disorder *depression, anxiety, bipolar, PTSD, etc.*	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Shoulder Injury:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Knee Injury:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Back Injury/Disease:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Arthritis:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)
Other:	☐ Yes Yr ⇨	☐ Yes ⇨	☐ Yes ⇨	1. _____ (_____) 2. _____ (_____)

Additional Information or Medications:

_____

_____

_____

17. Which, if any, of the following surgeries have you had *(please check one box per line)*.

Surgery	**Never**	**Within the 12 months**	**Previous to the past 12 months**	**Brief Description**
Chest:	☐	☐	☐	_____
Back:	☐	☐	☐	_____
Neck:	☐	☐	☐	_____
Shoulder:	☐	☐	☐	_____
Knee:	☐	☐	☐	_____
Hip Leg Ankle Foot	☐	☐	☐	_____
Other:	☐	☐	☐	_____

18. We would like to ask about screening tests you have had in the past year, and whether results were normal or required follow-up.

Screening Test	Within the past year	Normal	Abnormal	Brief Description
Testicular	☐	☐	☐	_____
FOB *Fecal Occult Blood (blood in stool)*	☐	☐	☐	_____
Colonoscopy	☐	☐	☐	_____
Pap Smear	☐	☐	☐	_____
Breast	☐	☐	☐	_____
Mammogram	☐	☐	☐	_____
Skin *biopsy or exam by physician*	☐	☐	☐	_____
Other:	☐	☐	☐	_____

19. How many days per week do you exercise or take part in cardiovascular or aerobic activities that made you sweat and breathe hard for at least 30 minutes? *Examples: basketball, tennis, jogging, fast bicycling etc.*

Average days per week : ☐ 1 – 3 ☐ 4 – 5 ☐ 6 – 7

20. Date of last flu shot: _____ NEED ☐ Yes ☐ No

Supplemental Information

Question Number	Detailed Information

(If Needed, Please Attach An Additional Sheet)

I hereby authorize the performance of a complete medical examination, x-rays, blood testing, and urine testing. I declare that my answers are true to the best of my knowledge and belief.

TYPED OR PRINTED NAME OF APPLICANT:	COMPLETE SIGNATURE:	DATE: