QUADRANT

MEDICAL HISTORY and EXPOSURES

IDENTIFICATION

Print name: _____ **Job Title:**	**Sex:** **M F**	**SS#:**	**Date of Birth:**
Primary language spoken:		**Interpreter needed:** **Yes No**	

MEDICATIONS

LIST ALL MEDICATIONS YOU TAKE Including all prescription / non-prescription, vitamins and herbal preparations:

ALLERGIES: YES NO
List all allergies:

HOSPITALIZATIONS

Outpatient medical services or procedures:

YEAR	REASON

MEDICAL HISTORY

CIRCLE ANY you've had or have:

Anemia	Diabetes	Hepatitis	Migraines	Seizures
Asthma	Emphysema	Herniated Disc	Positive skin test for TB	Thyroid trouble
Claustrophobia	Heart Attack	High Blood Pressure	Prostate Problems	Other Specify:
Collapsed Lung	Heart Murmur	Kidney Disease	Ruptured Ear Drum	_____

REVIEW OF SYSTEMS

CIRCLE ANY you've had or have:

General
Fevers greater than100 degrees
Shivering / Chills
Generalized Weakness
Unexplained Weight Loss / Gain
Excessive Fatigue
Swollen Glands
Loss of Appetite
Head Injury

Heart Lungs
Chest Pain / Pressure
Irregular Heart Beat
Palpitations / Skipped beats
New or Changed Cough
Coughing up blood
Wheezing
Shortness of breath

Neurological
Headaches
Depression
Numbness or Tingling
Excessive Anxiety
Insomnia / Difficulty Sleeping
Loss of Memory
History of Seizures

Ears Nose Throat
Difficulty Hearing
Ringing / Buzzing
Sinus trouble
Sneezing / Runny nose
Nose bleeds
Difficulty swallowing
Dry mouth
Dizziness

Genitourinary
Difficult or Painful urination
Blood in urine

MEN Only
Lump in testicle
Impotence

WOMEN Only
Breast lump / Discharge
Currently or Possibly Pregnant

Digestive System
Nausea / Vomiting
Diarrhea
Constipation
Rectal bleeding / black stool
Yellow jaundice
Abdominal pain

Skin / Musculoskeletal
Rashes
Moles that changed in color/size
Back Pain/Muscle pain
Neck Pain
Knee / ankle / foot pain
Shoulder / arm / hand pain
Weakness in arms legs

Eyes
Change in vision
Itching
Tearing

Teeth / Gums
Specify:
_____
_____

EXPOSURE HISTORY

CIRCLE ALL items worked with:

Asbestos	Extreme Hot / Cold	Sand Blasting	Loud noise	Mining
Chemicals	Radioactive material	Pesticides	Heavy Lifting	Vibration
Metals	Radiation	Silica	Repetitive motion	Other Specify:_____

Patient Signature / Consent:

I the undersigned, hereby certify that the information I have furnished on this form is true and correct. I authorize the examining provider to disclose to the client organization only information necessary for my employment status. This information is obtained from the details provided on this form and/or the findings during the course of the examination. I willingly submit to any required tests necessary to complete this examination.

Signature: _____ **Date**: _____

Parent/Guardian Signature: _____Witness: _____