



FirstMed Hazardous Material Medical History

NAME:	DATE:
EMPLOYER:	SS#:

Have you ever had, do you now have or have you ever been treated for any of the following?

LUNG DISEASE	Y	N	HEART DISEASE	Y	N	OTHER	Y	N
Tuberculosis			Hypertension			Diabetes		
Asthma			Low Blood Pressure			Kidney Disease		
Pneumonia			Heart Murmur			Seizure Disorder		
Shortness of Breath			Heart Palpitation			Breast Disease		
Hayfever			Heart Attack			Head Injury		
Bronchitis			Swelling of Ankles			Frequent Headaches		
Emphysema			Fainting Spells			Multiple Sclerosis		
Frequent Colds/Sore Throats			Varicose Veins			Hernia		
Chronic Cough						Hernia Repair		
						Loss of Weight		
DIGESTIVE	Y	N	JOINT DISEASE	Y	N	Tumor		
Ulcers			Trick Knee			Paralysis		
Colitis			Knee surgery			Anemia		
Stomach Trouble			Swollen Ankles			Cancer		
Intestinal Trouble			Joint Injury			Depression		
Gall Bladder			Arthritis			Thyroid		
Frequent Diarrhea			Rheumatism			Cysts		
Frequent Vomiting			Fractured Bone			Jaundice		
Stool Irregularity			Muscle Pain			Epilepsy		
			Bursitis					
			Elbow Pain					
			Hand Numbness/Tingling					
SKIN DISORDER	Y	N	ALLERGIES	Y	N	COMMENTS:		
Hives			Medicines					
Dermatitis			Oils					
Eczema			Chemicals					
Psoriasis			Soaps					
Rashes			Serum					
Other			Detergents					

Have you ever had ear trouble? YES /NO _____ Ear Surgery YES/ NO _____

Hearing Difficulty? YES /NO _____

Do you have eye problems? YES /NO _____ Wear Corrective Lenses YES /NO _____

Color Blindness? YES /NO _____

Are you now or have you taken any medication over the past two (2) months? YES/NO _____

If yes list medications: _____

Do you smoke? YES/NO _____ If so, how many packs per day? _____ How many years? _____

Have you ever collected compensation for an Industrial Injury or Illness? YES/NO _____

Have you had surgery in the past five (5) years? YES/NO _____

Has your physical activity been restricted during the past five years? YES/NO _____

Has your physical activity been restricted during the past five years? YES/NO _____

Have you received treatment for counseling for a nervous condition or emotional problem? YES/NO _____

Have you ever been treated for alcoholism or a drug habit? YES/NO _____

I have carefully read all the forgoing questions and hereby certify that the answers and information as to my identity, heath history, and all other matters referred to above are correct and true.

Signature: _____ Date: _____

Physician Comments: _____