		Initial Occupational Medical History

Hanford Occupational Health Services

In keeping with the Privacy Act of 1974, this is to inform you of the purposes for which information will be used and your rights, benefits and obligations with respect to supplying information.

CSC Hanford Occupational Health Services is an occupational medicine group concerned with continued health and safety of Hanford project employees. In order to do this, it is necessary to evaluate your health. For this reason, we need to know not only your medical history, but also your past work history and exposures, certain personal habits and family history.

The information you give will become part of your medical record. Occupational illnesses and injuries may also be recorded in your medical record. Information regarding occupational illnesses and injuries may be supplied to the U.S. Department of Labor and the Washington State Department of Labor and Industries. Information may be taken from your record for use in approved Human Subject Research.

Collection of this information is authorized under the Energy Reorganization Act of 1974, the Atomic Energy Act of 1954 as amended and other related acts. The privacy of your records is protected under the Privacy Act of 1974. This record system is identified as System DOE-33.

INSTRUCTIONS

In filling out the questionnaire please be as accurate as you can in your answers. If you are uncertain as to whether or not you ever had any of the medical conditions listed, answer NO to that specific question. Use a pen to complete the questionnaire. Please print legibly. Place an "X" in the appropriate block for each question.

When you have completed the questionnaire, please sign and date the last page and bring the questionnaire with you to your CSC HOHS Appointment

Have you read the instructions? If not, please turn to page one before completing the form.

PERSONAL INFORMATION

Name: _____
Last First Middle

Please list any other name you may have used:

(i.e. Maiden Name, etc…)

_____ _____ _____ _____
Social Security Number Date of Birth

Place of Birth: _____

Sex: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ Hispanic ☐ Black ☐ Oriental ☐ American Indian ☐ Other

Are you currently? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Were you ever in the military service? ☐ Yes ☐ No

If YES, please complete the following:

☐ US Military Rank/Grade _____

☐ Foreign Military

Branch ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard ☐ Res/Nat'l Guard

Job Title _____

Year of Enlistment _____ Year of Discharge _____

Present address: _____
Street

_____ _____ _____
City State Zip

Home Telephone ( ) -

Work Telephone ( )

Person to be contacted in an emergency situation:

Name: _____

Address: _____

Telephone: Home ( ) -
Work ( ) -

Family Record

Is your mother: ☐ Living ☐ Deceased?

If deceased, age at death _____

Cause of death: _____

Is your father: ☐ Living ☐ Deceased?

If deceased, age at death _____

Cause of death: _____

Do you have any brothers or sisters? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No

Allergies

Do you have any allergies? (If yes, please indicate)

☐ Drugs _____
☐ Foods _____
☐ Pollen _____
☐ Animal Dander _____
☐ Latex _____
☐ Other: _____

FAMILY ILLNESS RECORD

Have any of your close blood relatives (grandparents, parents, siblings or children) had any of the following medical problems? If yes, please indicate by checking the appropriate answer

	Parent	Sibling	Grandparent	Child
1. Tuberculosis	☐	☐	☐	☐
2. Diabetes	☐	☐	☐	☐
3. Kidney Disease	☐	☐	☐	☐
4. Heart Trouble	☐	☐	☐	☐
5. High blood pressure	☐	☐	☐	☐
6. Stroke	☐	☐	☐	☐
7. Cancer (any type)	☐	☐	☐	☐
8. Epilepsy/Seizure	☐	☐	☐	☐
9. Arthritis	☐	☐	☐	☐
10. Intestinal/Bowel disease	☐	☐	☐	☐
11. Glaucoma	☐	☐	☐	☐
12. Cataracts	☐	☐	☐	☐
13. Blindness	☐	☐	☐	☐
14. Accidental or self-inflicted death	☐	☐	☐	☐
15. Congenital (birth) defects	☐	☐	☐	☐
16. Blood disorders	☐	☐	☐	☐

1. Are you under the care of a physician for any injury or illness? ☐ Yes ☐ No

   If yes, name of physician: _____

2. Do you have any medical restrictions or significant illness? If yes, please describe. ☐ Yes ☐ No

3. Do you have any concerns related to prior illness, injuries or exposures? If yes, explain. ☐ Yes ☐ No

Are you currently taking medication? If yes please list and state reason for use. ☐ Yes ☐ No

Name of Medication	Condition Being Treated

HAVE YOU EVER OR DO YOU NOW:

4. Use tobacco products? ☐ Now ☐ Past ☐ Never
   If now or past, what kind & how many years?
5. Drink alcoholic beverage? ☐ Now ☐ Past ☐ Never
6. Had surgery? ☐ Yes ☐ No
   If yes, what kind and how long ago?

Have you ever been diagnosed with:

7. Asbestosis?	☐ Yes	☐ No	10. Lung Cancer?	☐ Yes	☐ No
8. Silicosis?	☐ Yes	☐ No	11. Broken ribs?	☐ Yes	☐ No
9. Pneumothorax?	☐ Yes	☐ No	12. Heat related illness?	☐ Yes	☐ No

Vision & Eyes

13. Eye or vision problems?	☐ Yes	☐ No
14. Glasses or contact lenses?	☐ Yes	☐ No
15. Cataracts?	☐ Yes	☐ No
16. Loss or change of vision for any reason?	☐ Yes	☐ No
17. Any other conditions involving the eyes?	☐ Yes	☐ No

Ears & Hearing

18. Any problems with your ears?	☐ Yes	☐ No

Mouth, Nose & Throat

19. Hay fever, allergies or sinus infections?	☐ Yes	☐ No
20. Throat or voice problems?	☐ Yes	☐ No
21. Nose problems?	☐ Yes	☐ No

Respiratory Tract

22. Asthma or wheezing with breathing?	☐ Yes	☐ No
23. Problems with your lungs?	☐ Yes	☐ No
24. Unusual shortness of breath?	☐ Yes	☐ No
25. Sleep apnea?	☐ Yes	☐ No

Endocrine and Diabetes

26. Diabetes?	☐ Yes	☐ No
27. Use Insulin?	☐ Yes	☐ No
28. Thyroid problems or take meds for thyroid?	☐ Yes	☐ No

Cardiovascular System and Blood

29. Anemia, blood diseases, or	☐ Yes	☐ No

bleeding problems?
30. Shortness of breath at night or with minimal exercise? ☐ Yes ☐ No
31. Chest pain with stress or exercise? ☐ Yes ☐ No
32. Heart attack or heart surgery? ☐ Yes ☐ No
33. Stroke or high blood pressure? ☐ Yes ☐ No

Gastrointestinal & Hepatic

34. Frequent abdominal pain? ☐ Yes ☐ No
35. Frequent difficulty with digestion? ☐ Yes ☐ No
36. Surgery on abdomen in past five years? ☐ Yes ☐ No
37. Hepatitis, yellow skin or jaundice? ☐ Yes ☐ No
38. Blood in stools? ☐ Yes ☐ No

Musculoskeletal

39. Unusual weakness, loss of feeling or control of your arms or legs? ☐ Yes ☐ No
40. Unusual pain in your muscles or joints? ☐ Yes ☐ No
41. Unusual restriction of motion in your joints? ☐ Yes ☐ No
42. Chronic back pain? ☐ Yes ☐ No

Central and Peripheral Nervous System

43. Seizures? ☐ Yes ☐ No
44. Fainting spells or dizziness? ☐ Yes ☐ No
45. Loss of memory or confusion? ☐ Yes ☐ No
46. Unusual weakness or loss of control in the legs or arms? ☐ Yes ☐ No
47. Numbness or tingling in the hands or feet? ☐ Yes ☐ No
48. Loss of sensation in the skin? ☐ Yes ☐ No
49. Severe head pain or migraine headaches? ☐ Yes ☐ No
50. Depression or mood problems? ☐ Yes ☐ No
51. Severe anxiety? ☐ Yes ☐ No

Skin

52. Problems or diagnosed disease of your skin? ☐ Yes ☐ No
53. Sunburn easily? ☐ Yes ☐ No

Renal & Urological

54. Problems with kidneys or bladder? ☐ Yes ☐ No
55. Difficulty urinating? ☐ Yes ☐ No
56. Frequent urination? ☐ Yes ☐ No
57. Blood in urine? ☐ Yes ☐ No

Men Only

58. Problem with prostate? ☐ Yes ☐ No

Women Only

59. Menstrual irregularities? ☐ Yes ☐ No
60. Abnormal pregnancy? ☐ Yes ☐ No

Occupational History

61. Have you ever been exposed to any of the following?
    a. Any chemical that made you sick? ☐ Yes ☐ No
    b. Radioactivity or radiation in doses likely to cause illness? ☐ Yes ☐ No
    c. Fumes – welding, lead, beryllium, or other metal ☐ Yes ☐ No
    d. Asbestos or silica? ☐ Yes ☐ No
    e. Beryllium? ☐ Yes ☐ No

If you were potentially exposed to beryllium at a DOE/DOD site or by working on a DOE/DOD activity, you're eligible for beryllium monitoring while employed on the Hanford site. Please contact CSC HOHS Beryllium Case Management at 376-6000 if you would like to enroll in the voluntary beryllium program.

The above information is complete to the best of my knowledge

Signature _____ Date _____

CSC HOHS Provider Comments

_____

_____

_____

_____

_____

_____ MD/DO/PA _____

Provider Signature Date