CORPORATE HEALTH SERVICES
A SERVICE OF SARATOGA HOSPITAL
2388 Route 9 • Mechanicville • NY • 12118
Tel: (518) 886-5412 • Fax: (518) 899-8069

Medical History

Name: _____ Sex: _____ Date of Birth: _____
Last First Middle

Address: _____
Street City State Zip Code

Home Phone: _____

Have you ever had, or do you now have, any of the following? Check Yes or No; if yes, indicate age:

	Yes	No	Age
Surgery or severe injury			
Cancer / Tumor / Cyst			
Anemia or blood disease			
Diabetes			
High Blood Pressure			
Thyroid problems			
Eczema / Hives / Skin problems			
Ear / Nose / Throat problems			
Eye problems			
Lung problems			
Heart problems			
Chicken Pox			
MMR			
Rheumatic or scarlet fever			
Phlebitis or blood clot			

	Yes	No	Age
Abdominal / Ulcer problems			
Kidney stones or kidney disease			
Bladder or prostate problems			
Hernia (rupture)			
Hemorrhoids or rectal disease			
Varicose veins			
Hand/Wrist/Elbow/Shoulder problems			
Foot / Ankle / Knee / Hip problems			
Head / Neck / Spinal problems			
Back pain			
Neurological problems			
Emotional or psychiatric problems			
Neuritis or pinched nerves			
Stroke paralysis			
Other			

Please explain "Yes" answers: _____
_____
_____
_____
_____

Date of last tetanus shot: _____ Date of last Tuberculosis (TB) test: _____

Do you take medication? ☐ Yes ☐ No If yes, please list them: _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, to what? _____

Allergies other than medications: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much? _____

Do you use illegal drugs? ☐ Yes ☐ No

Do you now, or have you ever, belonged to a substance abuse support group? ☐ Yes ☐ No

Do you presently smoke? ☐ Yes ☐ No If yes, # of cigarettes per day: _____ # of years: _____

Did you used to smoke regularly? ☐ Yes ☐ No If yes, # of cigarettes per day: _____ # of years: _____

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Do you, or have you, lived next door to or very near an industrial plant? ☐ Yes ☐ No

Do you have a hobby or craft which you do at home? ☐ Yes ☐ No Describe: _____

Do you use pesticides around your home or garden? ☐ Yes ☐ No

Occupational History

Company: _____

Job: _____

Please list most recent job first, and then work backwards in time:

Approximate Dates	Employer Name and Location	Known Health Hazard Exposures

		Yes	No
1.	Have you ever been rejected or uprated for insurance because of health?	☐	☐
2.	Have you been rejected from employment, or the Armed Forces, because of health?	☐	☐
3.	Has your work ever been limited or restricted because of health?	☐	☐
4.	Have you ever filed a Worker's Compensation claim?	☐	☐
5.	Have you ever received benefits from a Worker's Compensation claim?	☐	☐
6.	Have you lost more than five consecutive days from work, in the past three years, because of illness or injury?	☐	☐
7.	Do you have a condition requiring a special work assignment or work aids?	☐	☐
8.	Have you developed hearing problems from noise exposure?	☐	☐
9.	Have you had problems due to work with vibrating tools?	☐	☐
10.	Have you had occupational radiation exposure?	☐	☐
11.	Have you had problems because of exposure to solvents, fumes, chemicals, dust or latex?	☐	☐
12.	Have you had problems with any occupational materials irritating to you?	☐	☐

Please explain "Yes" answers: _____

_____

_____

_____

_____

To the best of my knowledge, I cerify that the above answers are true and complete.

Signature: _____ Date: _____