

The Saratoga Hospital
Corporate Health Services

Page 1 of 5

Detailed Medical Surveillance Questionnaire

Company Name _____ Date _____

Employee Name _____

Job Title _____

Age: _____ Birthdate: _____ Sex: _____

Height: _____ Weight: _____

Baseline Exam: Yes No

Medical History

1. Have you ever been in the hospital as a patient? Yes No
If Yes, what kind of problem were you having? _____

2. Have you ever had any kind of operation? Yes No
If Yes, what kind? _____

3. Do you take any kind of medicine regularly? Yes No
If Yes, please list Medications and condition being treated:

Medication	Condition

4. Are you allergic to any drugs, foods, or chemicals? Yes No
If Yes, what is it and what is your reaction? _____

5. Do you take any dietary or herbal supplements, street drugs, anabolic steroids or growth hormone? Yes No
If Yes, please list: _____

6. Are you on a special diet, diet drinks, energy or protein shakes? Yes No
If Yes, please describe: _____

7. Have you ever been told that you have asthma, hay fever, or sinusitis? Yes No

8. Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems? Yes No
If Yes, what kind of problem, and when was it diagnosed? _____

9. Have you ever been told you had hepatitis? Yes No
If yes, what kind? _____

10. Have you ever been told that you had cirrhosis? Yes No

The Saratoga Hospital
Corporate Health Services

Page 2 of 5

11. Have you ever been told that you had cancer? Yes No
If Yes, what kind? _____
12. Do you have arthritis or suffer from chronic joint pain? Yes No
If Yes, please describe: _____
13. Have you ever been told that you had high blood pressure? Yes No
14. Have you ever had a heart attack or heart trouble? Yes No
15. Do you wear glasses or contact lenses? Yes No
16. Have you been under the care of a physician during the past year? Yes No
If Yes, for what condition? _____
17. Is there any change in your breathing since last year? Yes No
If Yes, how has it changed and do you know why? _____

Occupational and Social History

1. How long have you worked for your most recent employer? _____
2. What jobs have you held with this employer? Include job title and length of time in each job.

3. In each of these jobs, how many hours a day were you exposed to chemicals or dust?

4. What chemicals have you worked with most of the time? _____

5. What personal protective gear was provided to you to protect you from exposure to these chemicals?

6. Do you wear the personal protective gear provided to you? Yes No
If No, why not? _____
7. What job(s) did you have prior to the most recent job? Please list the approximate dates, and any known exposures.

Employer	Dates	Exposures

The Saratoga Hospital
Corporate Health Services

Page 3 of 5

8. In your work history, have you ever had exposure to:

Wood dust: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cadmium: <input type="checkbox"/> Yes <input type="checkbox"/> No	Arsenic or asbestos: <input type="checkbox"/> Yes <input type="checkbox"/> No
Nickel: <input type="checkbox"/> Yes <input type="checkbox"/> No	Chromium: <input type="checkbox"/> Yes <input type="checkbox"/> No	Silica (foundry, sand blasting)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No	Organic solvents: <input type="checkbox"/> Yes <input type="checkbox"/> No	Urethane foams? <input type="checkbox"/> Yes <input type="checkbox"/> No

9. Do you smoke? Yes No

If Yes, how much and for how long?

Pipe _____

Cigars _____

Cigarettes _____

10. Do you drink alcohol in any form? Yes No

If Yes, how much, how long, and how often?

Liquor _____

Beer _____

Wine _____

11. Are you exposed to any dust or chemicals at home? Yes No

If Yes, please explain. What is the exposure, how much and for how long?

12. Do you have any hobbies or "side jobs" that require you to use chemicals, such as furniture stripping, sand blasting, insulation or manufacture of urethane foam, furniture, etc? Yes No

If Yes, please describe, giving type of business or hobby, chemicals used and length of exposures. _____

13. Do you get any physical exercise other than that required to do your job? Yes No

If Yes, explain: _____

Symptoms Questionnaire

1. Do you ever have any shortness of breath? Yes No

If Yes, do you have to rest after climbing several flights of stairs? Yes No

If Yes, if you walk on the level with people your own age, do you walk slower than they do? Yes No

2. Do you cough frequently? Yes No

If Yes, is this caused by exposure to a specific material or air temperature?

If so, please describe _____

3. Do you cough as much as three months out of the year? Yes No

If Yes, have you had this cough for more than two years? Yes No

If Yes, do you ever cough anything up from your chest? Yes No

4. Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest? Yes No

If Yes, do you notice this on any particular day of the week? Yes No

The Saratoga Hospital
Corporate Health Services

Page 4 of 5

-
- If Yes, do you notice that this occurs at any particular place? Yes No
If Yes, do you notice that this is worse after you have returned to work after being off for several days? Yes No
5. Have you ever noticed any wheezing in your chest? Yes No
If Yes, is this only with colds or other infections? Yes No
Is this caused by exposure to any kind of dust or other material? Yes No
If Yes, what kind? _____
6. Have you noticed any burning, tearing, or redness of your eyes when you are at work? Yes No
If Yes, explain circumstances: _____
7. Have you noticed any sore or burning throat or itchy or burning nose? Yes No
If Yes, please explain the circumstances: _____
8. Have you noticed any stuffiness or dryness of your nose? Yes No
9. Do you ever have swelling of the eyelids or face? Yes No
10. Have you ever been jaundiced? (yellowing of skin or eyes) Yes No
If Yes, was this accompanied by any pain? Yes No
11. Have you ever had a tendency to bruise easily or bleed excessively? Yes No
12. Do you have frequent headaches that are not relieved by aspirin or tylenol? Yes No
If Yes, do they occur at any particular time of the day or week? Yes No
If Yes, when? _____
13. Do you have frequent episodes of nervousness or irritability? Yes No
14. Do you tend to have trouble concentrating or remembering? Yes No
15. Do you ever feel dizzy, light-headed, excessively drowsy or feel like you have been drugged? Yes No
16. Does your vision ever become blurred? Yes No
17. Do you have numbness or tingling of the hands or feet or other parts of your body? Yes No
18. Have you ever had chronic weakness or fatigue? Yes No
19. Have you ever had any swelling of your feet or ankles to the point where you could not wear your shoes? Yes No
20. Are you bothered by heartburn or indigestion? Yes No
21. Have you ever noticed any type of skin rash you feel was related to your work? Yes No
22. Do you ever have itching, dryness, or peeling and scaling of the hands? Yes No
23. Do you ever have a burning sensation in the hands, or reddening of the skin? Yes No
24. Do you ever have cracking or bleeding of the skin on your hands? Yes No

The Saratoga Hospital
Corporate Health Services

Page 5 of 5

25. Have you ever been told that you have kidney or bladder problems? Yes No

26. Have you ever passed blood in your urine? Yes No

27. Do you have any physical complaints today? Yes No

If Yes, please explain: _____

28. Do you have other health conditions not covered by these questions? Yes No

If Yes, please explain: _____

I certify that I have answered these questions truthfully and to the best of my ability.

Patient Signature

Date / Time

Reviewed by

Date / Time