**Orientation - Medical History**

All information on this form will be kept confidential by Occupational Health Services.

|  |  |
| --- | --- |
| Name: | |
| Address: | Birthdate: |
| City: | SIN: |
| Province: | HCN: |
| Postal Code: | Family Physician: |
| Phone Number: | Date of Hire: |
| Department: |  |
| EMERGENCY CONTACT: Name:       Phone: | |

Please list any allergies:

If you are currently experiencing, or have experienced any of the following in the past, please click an ‘X’ in each box that applies:

Arthritis, Rheumatism or Gout  Dizziness or Fainting  Persistent Cough

Asthma  Epilepsy/Seizures  Recurrent Back Pain

Chest Pain or Discomfort  Foot Problems  Shortness of Breath

Communicable Diseases  Frequent/Severe Headaches  Skin Disease

Decreased Hearing  Heart Disease  Tuberculosis

Diabetes  Hepatitis  Tumor or Cancer

Difficulty Walking or Climbing Stairs  High Blood Pressure  Vision Problems

Are you currently receiving treatment for any medical condition?  Yes  No

If yes, please specify:

Are you aware of any diseases, abnormalities or family concerns that the Occupational Health

Co-ordinator should know about?  Yes  No

If yes, please specify:

Please check “🗸” if you wear any of the following:

Glasses  Contact Lenses

Hearing Aid:  Left:  Right:

Dentures:  Top:  Bottom:

Do you take any medication regularly or occasionally?  Yes  No

If yes, please specify:

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Frequency** |
|  |  |  |
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Please list names of toxic substances you have been in contact with in previous occupations (i.e., lead, mercury, noise, chemotherapy drugs, ethylene oxide, asbestos, etc.):

Are you drawing any disability benefits from any source now or did you in the past?  Yes  No

If yes, please explain:

Do you use tobacco?  Yes  No

If yes, would you be interested in a smoking cessation program?  Yes  No

When did you last have the following?

Medical exam: Year

Dental exam: Year

Eye exam: Year

The above information is true and accurate to the best of my knowledge.

Signature: Date: