Nationwide Children's Hospital Employee Health

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date:	**SSN #**	
Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB** **AGE:**
Address:		**Phone:** **E-mail:**
Unit/Dept. Assigned:	**Job Title:**	
Primary Care Physician:	**Phone#**	
Emergency Contact Name and Number:	**Phone #**	

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox

List Any Medical Problems That Other Doctors Have Diagnosed:

List Any Previous Work Related Injuries:

Surgeries:

Year	Reason

Other Hospitalizations:

Year	Reason

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency Taken

Allergies

Medications:	Reaction You Had:

Environmental or Food Allergies:

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Tobacco:
☐ I am aware of NCH non smoking policy

Do you use tobacco? ..... ☐ Yes ☐ No
☐ Cigarettes - Pks/day ☐ Chew - #/day ☐ Pipe - #/day
☐ Cigars - #/day ☐ # of Years ☐ or Year Quit

REVIEW OF SYSTEMS- to document current or chronic health issues

General Well-being
☐ Yes ☐ No Fever
☐ Yes ☐ No Weight Loss
☐ Yes ☐ No Excessive Fatigue
☐ Yes ☐ No Recurrent nausea/vomiting
☐ Yes ☐ No Night sweats
☐ Yes ☐ No Sleep Apnea
☐ Yes ☐ No Narcolepsy
Comments:_____
_____

Eyes
☐ Yes ☐ No Wear glasses/contacts
☐ Yes ☐ No Blurred vision
☐ Yes ☐ No Trouble focusing
☐ Yes ☐ No Recent change in vision
Comments:_____
_____

Cardiovascular
☐ Yes ☐ No Chest pain
☐ Yes ☐ No Heart disease
☐ Yes ☐ No High Blood pressure
☐ Yes ☐ No Low blood pressure
☐ Yes ☐ No Irregular heartbeat
☐ Yes ☐ No Racing heartbeat
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Arm and leg swelling
☐ Yes ☐ No High cholesterol
Comments:_____
_____

Respiratory
☐ Yes ☐ No Chronic cough
☐ Yes ☐ No Asthma
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Bronchitis
☐ Yes ☐ No Chronis Obstruction Pulmonary Disease
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Pneumonia
☐ Yes ☐ No Lung cancer
☐ Yes ☐ No Tuberculosis or Positive TB Skin test

Genitourinary
☐ Yes ☐ No Pain/burning with urination
☐ Yes ☐ No Blood in urine
☐ Yes ☐ No Urinary tract infection
☐ Yes ☐ No Difficulty urinating
☐ Yes ☐ No Incontinence
☐ Yes ☐ No Kidney stones
☐ Yes ☐ No Prostate enlargement
☐ Yes ☐ No Endometriosis
☐ Yes ☐ No Cervical/ovarian/uterine cancer
Comments:_____
_____

Neurological
☐ Yes ☐ No Disorientation
☐ Yes ☐ No Fainting/blackout spells
☐ Yes ☐ No Light headedness
☐ Yes ☐ No Seizures
☐ Yes ☐ No Stroke
☐ Yes ☐ No Memory/concentration problems
☐ Yes ☐ No Speech problems
☐ Yes ☐ No Facial weakness/paralysis
☐ Yes ☐ No Muscle weakness
☐ Yes ☐ No Coordination problems
☐ Yes ☐ No Headache
☐ Yes ☐ No Migraines
Comments:_____
_____

Endocrine
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Hormone problems
☐ Yes ☐ No Low blood sugar
☐ Yes ☐ No Thyroid disease
☐ Yes ☐ No Increased appetite
☐ Yes ☐ No Excessive thirst
☐ Yes ☐ No Temperature intolerance

Comments:_____
_____

☐ Yes ☐ No Blood in saliva
Comments:_____

Ears, nose, mouth, and throat

☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Hearing aid
☐ Yes ☐ No Ear infection
☐ Yes ☐ No Pressure in ears
☐ Yes ☐ No Ringing in ears
☐ Yes ☐ No Itching in ears
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Nasal congestion/drainage
☐ Yes ☐ No Nosebleeds
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Throat infections
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Lip or mouth sores
☐ Yes ☐ No Bad breath
☐ Yes ☐ No Gum Disease
☐ Yes ☐ No Oral Cancer
Comments:_____
_____

Gastrointestinal

☐ Yes ☐ No Blood in vomit
☐ Yes ☐ No Heartburn
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Stomach/abdominal pain
☐ Yes ☐ No Constipation
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Change in bowel habits
☐ Yes ☐ No Black or tarry stools
☐ Yes ☐ No Rectal bleeding
☐ Yes ☐ No Hemorrhoids
☐ Yes ☐ No Stomach/liver, colon cancer
☐ Yes ☐ No Gallbladder disease

Comments:_____
_____

Hematologic

☐ Yes ☐ No Anemia
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Easy bleeding/bruising
☐ Yes ☐ No Swollen glands

Comments:_____
_____

Immunologic

☐ Yes ☐ No Hay fever
☐ Yes ☐ No Immune system problems
☐ Yes ☐ No Frequent colds/infections
☐ Yes ☐ No HIV/AIDS
Comments:_____
_____

Skin

☐ Yes ☐ No Eczema or psoriasis
☐ Yes ☐ No Dry or scaling skin
☐ Yes ☐ No Rashes
☐ Yes ☐ No Changes in skin color
☐ Yes ☐ No Changes in moles
☐ Yes ☐ No Skin cancer
Comments:_____
_____

Musculoskeletal

☐ Yes ☐ No Back pain
☐ Yes ☐ No Arm or leg pain
☐ Yes ☐ No Joint pain or swelling
☐ Yes ☐ No Broken bones
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Back injury
Comments:_____
_____

Psychiatric

☐ Yes ☐ No Anxiety
☐ Yes ☐ No Depression
☐ Yes ☐ No Panic attacks
☐ Yes ☐ No Sudden moods swings
☐ Yes ☐ No Emotional difficulties
☐ Yes ☐ No Insomnia
☐ Yes ☐ No Other psychiatric problems
☐ Yes ☐ No ADD/ADHD
Comments:_____
_____

Other Comments:_____
_____
_____
_____
_____

WOMEN ONLY

Period every _____ days. Heavy periods, irregularity, spotting, pain, or discharge? ..... ☐ Yes ☐ No
Are you pregnant or breastfeeding? ..... ☐ Yes ☐ No
Have you had a D&C, hysterectomy, or Cesarean section? ..... ☐ Yes ☐ No
Any hot flashes or sweating at night? ..... ☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge? ..... ☐ Yes ☐ No
Date of last pap smear and rectal exam?
Comments:_____

MEN ONLY

Do you usually get up to urinate during the night? ..... ☐ Yes ☐ No If yes, # of times
Do you feel pain or burning with urination? ..... ☐ Yes ☐ No
Do you have any problems emptying your bladder completely? ..... ☐ Yes ☐ No
Any testicle pain or swelling? ..... ☐ Yes ☐ No
Date of last prostate and rectal exam?

**Authorization to communicate lab result values/follow up instructions.
I hereby ___**authorize** ___**decline** for Nationwide Children's Hospital Employee Health to notify me of lab results and/or follow up instructions. It is my preference to be notified by ___**e-mail** or __**telephone message**.

Employee signature: _____ Date: _____

FOR EMPLOYEE HEALTH NURSE ONLY

PHYSICAL FINDINGS

VITAL SIGNS: Temperature:_____ Pulse Rate:_____ Respirations:_____ Lung Sounds: ☐ CTA OTHER:_____	Blood Pressure_____/_____ ____ Follow-up recommended: Requested information:
Height:	**Weight:**

Signature: _____ Date: _____

Revised 06/20/13