NorthShore University HealthSystem

OMEGA
Corporate and Occupational Health Services

HEALTH HISTORY

This is a very extensive health history. The information you give about your health history which DOES NOT RELATE TO YOUR JOB, or the JOB YOU ARE APPLYING FOR IS STRICTLY CONFIDENTIAL.

Do you have any religious or cultural beliefs that we should know about that could affect your care? ☐ No ☐ Yes

Have you ever been employed by NorthShore University HealthSystem? ☐ No ☐ Yes If yes, what year__________________

PLEASE PRINT

LAST NAME	FIRST NAME	MIDDLE NAME	DATE
STREET ADDRESS	CITY	STATE ZIP	HOME PHONE ( )
DATE OF BIRTH	AGE	MARITAL STATUS M S W D	SEX
PERSONAL PHYSICIAN		CITY	
DATE OF LAST TETANUS BOOSTER	YOUR NEW COMPANY'S NAME		
YOUR NEW JOB			

PLEASE LIST ALL OF YOUR CURRENT:

MEDICATIONS: ____

____

HERBS, HERBAL PREPARATIONS OR HOMEOPATHIC PREPARATIONS: ______________________

ALLERGIES:____

Allergic to Latex (i.e. - rubber gloves) - yes or no If yes, symptoms ______________________

Please answer all the questions. When you answer yes, please give details. Thank you for your cooperation.

HEALTH HISTORY

	YES	NO	IF "YES" GIVE DETAILS
HAVE YOU HAD ANY SURGERIES/OPERATIONS:			
On Your Back, Arm, Leg or Knee			
To Treat A Hernia			
Childbirth			
Any "OTHER" Operations			
HAVE YOU EVER BEEN HOSPITALIZED?			
HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Serious Allergy			
Bad Reaction To Any Medication			
Advised Not To Take Any Medication (i.e., Aspirin)			
SKIN — HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Hives Eczema Or Rash			
Chronic Skin Problems (i.e., Cuts Slow To Heal, Open Wounds)			
Excessive Skin Dryness			
Problems With "Easy" Bruising			
Chemical Or Jewelry Rash/Sensitivity			

HEALTH HISTORY Continued

	YES	NO	IF "YES" GIVE DETAILS
NEURO-HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Do You Snore?			
Are You Tired After You Sleep?			
Do You Nod Off During The Day?			
A Psychiatric Or Emotional Problem			
Have You Been Diagnosed With Sleep Apnea?			
Numbness/Weakness/Or Paralysis			
Dizziness Or Fainting Spells			
Severe Or Frequent Migraine Headaches			
Head Injury, Concussion Or Skull Fracture			
Neurological Disorders			
Seizures Or Blackouts			
Stroke			
Other			
EAR/EYE-HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Hearing Loss			
Frequent Ear Infections			
Ringing In Ears			
Other Ear Problems			
Glaucoma Or Cataracts			
Red Eyes			
Eye Injury/Vision Loss			
Other Eye Problems			
Glasses/Contacts			
Date Of Last Vision Screen			
HEAD/NECK-HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Date of Last Dental Exam:			
Recent Problems With Teeth/Dentures			
Frequent Mouth Ulcers/Infections			
Sinus Or Hay Fever			
Frequent Sore Throats Or Strep Throat			
Frequent Nose Bleeds			
Trouble With Thyroid (i.e.Taking Thyroid Medication)			
Problem Requiring Radiation Treatment To The Neck Area			
LUNGS-HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Asthma Or Wheezing			
Coughed Up Any Blood			
Bothered By Shortness Of Breath Without Apparent Reason			
Tuberculosis Or A Positive Skin Test For Tuberculosis			
Pneumonia Or Pleurisy			
Cough Every Day, Especially In The Morning			
Pain Or Tightness In Chest			
More Than Three Episodes Of Bronchitis In One Year			
Had A Chest X-Ray			Last Time:________________________________
HEART-HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Heart Murmur Or Rheumatic Fever			
Heart Disease			
Chest Pain With Activity			
Treated For Heart Condition			
Unusually Cold Or Bluish Colored Hands Or Feet			
High Blood Pressure - If "Yes" How Is It Treated			☐ Medicine ☐ Diet ☐ Exercise________________________
Do You Have A History Of Elevated Cholesterol			
Anemia Or Any Blood Disease			
Phlebitis, Varicose Veins Or Blood Clots/Poor Circulation			

HEALTH HISTORY Continued

	YES	NO	IF "YES" GIVE DETAILS
GI - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Ulcers, Indigestion, Pain Or Burning In Stomach			
Hiatal Hernia Or GERD			
Vomiting Of Blood			
Blood/Tarry Bowel Movements			
Infectious Diarrhea (e.g.Salmonella)			
Frequent Loose Bowel Movements			
Colitis Or Nervous Stomach			
Yellow Jaundice Or Hepatitis			
Problems With Your Pancreas			
Gallbladder Disease			
Hernia			
KIDNEYS - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE			
Bladder Or Kidney Infections			
Kidney Stones			
Burning Or Discomfort On Urination Or Frequent Urination			
Blood In Urine			
MISCELLANEOUS - HAVE YOU HAD OR DO YOU CURRENTLY HAVE:			
Diabetes Or Sugar In Your Urine			
Cancer Of Any Kind			
MUSCULO-SKELETAL-HAVE YOU HAD OR DO YOU CURRENTLY HAVE:			
Arthritis Or Rheumatism			
Been Treated For A Neck or Back Problem			
Recurrent Back Pain			
Bursitis, Tendonitis			
Any Broken Bones			
Recurrent Pulled Muscles Or Sprains			
Any Hand or Wrist Injury or Problem			
Any Joint Problems			
Job Requiring Heavy Lifting Or Standing, Or Sitting For Long Periods Of Time			
Have You Had Any Illness Or Injury That We Have Not Asked You About?			
GENERAL LIFESTYLE. Check The Answer That Best Describes You.			
Do You Ever Feel Guilty About The Amount Of Alcohol You Drink, Or Your Actions Under The Influence Of Alcohol?			
Have You Ever Needed An "Eye-Opener" (A Drink In The Morning)?			
Have You Ever Used Tobacco In Any Form?			How Long ________Yrs. Pack/Day________ When Quit__________
Do You Exercise 3 Times Per Week? 30-40 Minutes Each Time			Identify Types If Yes.
Are You More Than 30% Above Your Ideal Weight?			
Have You Received A Tetanus Booster In The Last 10 Years?			
Have You Been Immunized Against Hepatitis B?			Year Immunized:______________
Do You Take Non-Prescription Medication (Or "Over The Counter") Drugs On A Regular Basis?			
WORK HISTORY I. HAVE YOU EVER:			
Been Restricted In Your Work Or Given "Light Duty" Because Of Your Health Or Injury			
Left A Job Because Of Health Problems			
Been Injured On The Job And Treated By A Doctor			
Received Compensation For An Industrial Injury Or Illiness			
Are You Receiving Any Health Care Treatment (i.e. Physical Therapy Chiropractic, Acupuncture, Medical, Etc.)			
WORK HISTORY II. :			
Do You Have Hobbies Such As Furniture Refinishing, Painting, Hunting, Shooting Or Model Building?			
Do You Moonlight Or Have A Second Job?			

WORK HISTORY III.: JOBS - START WITH MOST RECENT			
Date (Year To Year)	Company	Position	Any Work Hazards or Chemical Exposures

I certify that the above information is true and complete to the best of my knowledge. I hereby give NorthShore OMEGA permission to release **only work related information** to the proper authorities of my employer or the company for which I am a job applicant.

I hereby authorize the NorthShore OMEGA physician or his designee to perform a physical examination, provide any necessary treatment and report to my employer/prospective employer, my physical qualifications to perform my duties.

Date:____________________________ Patient Signature: ____

Examiner Signature: ____