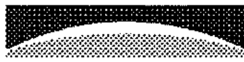

SARATOGA HOSPITAL
MEDICAL GROUP
OCCUPATIONAL MEDICINE
2388 ROUTE 9 • MECHANICVILLE • NY • 12118
TEL: (518) 886-5412 • FAX: (518) 899-8069

DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

Medical History

Name: ______________________ Gender: ________ Date of Birth: _____/_____/_____

Address: ______________________ City: ____________ State: ______ Zip: __________

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
Been hospitalized			
Surgery or severe injury			
Cancer / tumor / cyst			
Anemia or blood disease or easy bruising			
Diabetes, sugar problems			
High blood pressure / Hypertension			
Thyroid / other gland problems			
Eczema / hives / skin problems			
Eye / ear / nose / throat problems			
Hearing loss			
Eye or vision disorders			
Lung problems / COPD			
Tuberculosis / TB			
Pneumonia, bronchitis, asthma			
Emphysema / chronic cough / wheezing			
Heart Problems, heart attack, last EKG			
Exercise intolerance or SOB			
Chicken pox			
Measles / Mumps / Rubella			
Rheumatic or scarlet fever			
Varicose veins, phlebitis, blood clot			
Leg swelling or edema			

	Yes	No	Age
Ovaries / uterus / breast disease			
Pregnant			
Kidney stones or disease			
Blood / protein / sugar in urine			
Bladder or prostate problems			
Hernia (rupture)			
GI / abdominal / ulcer problems			
Hemorrhoids or recta disease			
Diarrhea / colitis			
Hand / wrist / elbow / shoulder problems			
Foot / ankle / knee / hip problems			
Other orthopedic problems			
Back / head / neck / spinal problems			
Herniated disc			
Neuritis or Pinched nerves			
Rheumatism / arthritis / gout			
Trouble with memory or concentrating			
Headaches or neurological problems			
Chronic Fatigue Syndrome			
Emotional or psychiatric problems			
Seizure / Epilepsy / Stroke / Paralysis			
Recent / unintentional weight gain / loss			

Please explain "Yes" answers: ______________________

____

____

____

Date of last tetanus shot: ______________

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

Pharmacy name and phone number: ______________

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 have any alcohol related problems? ☐ Yes ☐ No Please explain: ______________

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Do you use illegal drugs? ☐ Yes ☐ No

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

History of tobacco smoking? ☐ Yes ☐ No If yes, # of cigarettes per day: ______ # of years: ________

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

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

Have you travelled internationally within the last few months? ☐ Yes ☐ No

Do you have a primary care provider? (Family doctor) ☐ Yes ☐ No If yes, please name: ____________________

Occupational History

Current Company: ____

Current Job: ____

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

Approximate Dates	Employer Name and Location	Known Health Exposures

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

Please explain "Yes" answers: ____

____

____

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

Patient Signature: ______________________________ Date/Time: ________/________