Patient Name:_____

Medical Record Number:_____

Contact Serial Number:_____

HAR#:_____

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

OCCUPATIONAL HEALTH ASSESSMENT

Employer: _____

Job Title: _____

Age: _____

Health History

Have you ever experienced any of the following: (circle yes/no) Do not write in blank area.

Vision problems	Yes/No		Bowel Disorder	Yes/No	
Hearing/ear problems	Yes/No		Anxiety/depression	Yes/No	
Nose/sinus/throat problems	Yes/No		Fainting/dizzy spells	Yes/No	
Seasonal Allergies	Yes/No		Seizures	Yes/No	
Bleeding tendencies	Yes/No		Head injury or “knocked out”	Yes/No	
Blood disorders	Yes/No		Numbness/tingling	Yes/No	
Cancer/leukemia	Yes/No		Headaches	Yes/No	
Blood transfusion(s)	Yes/No		Disc disease	Yes/No	
Heart trouble	Yes/No		Back pain	Yes/No	
Chest pain	Yes/No		Neck pain	Yes/No	
High blood pressure	Yes/No		Joint pain	Yes/No	
Thyroid disease	Yes/No		Tennis elbow	Yes/No	
Diabetes	Yes/No		Sprains/strains	Yes/No	
Blood in urine	Yes/No		Broken bones/fractures	Yes/No	
Hernia/rupture	Yes/No		Arthritis	Yes/No	
Kidney problems	Yes/No		Carpal tunnel	Yes/No	
Lung disorders	Yes/No		Tendonitis	Yes/No	
Shortness of breath	Yes/No		Skin problems/rash	Yes/No	
Stomach problems	Yes/No		Substance abuse or addiction (drugs/alcohol)	Yes/No	
Liver/hepatitis disease	Yes/No		Previous surgery	Yes/No	
Ulcers/gastritis	Yes/No		Hospitalized in last 12 months	Yes/No	

Patient Name:_____

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HAR#:_____

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

OCCUPATIONAL HEALTH ASSESSMENT

Health History

Please list current medications/herbals/supplements: _____

_____

_____

Allergies: _____

Do you drink more than 1 alcoholic drink per day?	Yes	No
If so, how many per day or per week? _____		
Do you smoke cigarettes, cigars, or a pipe?	Yes	No
If so, how many per day? _____		
If you used to smoke, when did you quit? _____		
Do you chew tobacco?	Yes	No
If so, how much per day or per week? _____		

Work History

Do you have a permanent/impaired disability or condition, which requires or has required a special job assignment?	Yes	No
Have you ever had a work related illness or injury or a work comp claim?	Yes	No
Have you ever changed jobs for health reasons?	Yes	No
Do you have any respiratory problems related to work?	Yes	No
Do you have any skin problems related to work?	Yes	No

I hereby certify the information given on this questionnaire is true and accurate to the best of my knowledge. I understand falsification or withholding information may be reason for dismissal.

Signature: _____ Date: _____