**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** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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: