Health History Questionnaire for Occupational Workers

Personal Information

Full Name

Date of Birth

Gender

Select

Employee ID/Number

Department/Position

Contact Number

Medical History

Do you currently have or have you ever had (check all that apply):

Asthma

Tuberculosis (TB)

Allergies

High Blood Pressure

Diabetes

Epilepsy/Seizures

- [ ]

Heart Disease

- [ ]

Hearing Problems

- [ ]

Vision Problems

- [ ]

Other (specify below)

If other, please specify

Current Medications (if any)

Occupational Exposure

Are you currently or have you been exposed to any of the following at work? (check all that apply):

- [ ]

Chemicals/Solvents

- [ ]

Dust

- [ ]

Noise

- [ ]

Biological Agents

- [ ]

Physical Strain

- [ ]

None

Please specify type/frequency of exposure & duration

Lifestyle

Do you smoke?

Select

Do you drink alcohol?

Select

How often do you exercise?

Select

Additional Comments or Concerns

Signature

Date