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#:

Detailed Medical Surveillance Questionnaire

Employee Name: ______________________ Date: ____________

Company Name: ______________________

Job Title: ______________________

Baseline Exam: ☐ Yes ☐ No

Medical History

1. Have you ever been in the hospital as a patient? ☐ Yes ☐ No
   If yes, what kind of problem were you having? ______________________

2. Have you ever had any kind of operation? ☐ Yes ☐ No
   If yes, what kind? ______________________

3. Do you take any kind of medicine regularly? ☐ Yes ☐ No
   If yes, please list medication and condition being treated:

Medication	Condition

4. Are you allergic to any drugs, foods, or chemical? ☐ Yes ☐ No
   If yes, what is it and what is your reaction? ______________________

5. Do you take any dietary or herbal supplements, street drugs, anabolic steroids or growth hormone? ☐ Yes ☐ No
   If yes, please list: ______________________
6. Are you on a special diet, diet drinks, energy or protein shakes? ☐ Yes ☐ No
   If yes, please describe: ______________________

7. Have you ever been told that you have asthma, hay fever, or sinusitis? ☐ Yes ☐ No
8. Have you ever been told that you have emphysema, bronchitis or any other respiratory problems? ☐ Yes ☐ No
   If yes, what kind of problem and when was it diagnosed? ______________________

9. Have you ever been told you had Hepatitis? ☐ Yes ☐ No
   If yes, what kind? ______________________
10. Have you ever been told that you had Cirrhosis? ☐ Yes ☐ No

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#:

11. Have you ever been told that you had cancer? ☐ Yes ☐ No
    If yes, what kind? ______
12. Do you have arthritis or suffer from chronic joint pain? ☐ Yes ☐ No
    If yes, please describe: ______
13. Have you ever been told that you had high blood pressure? ☐ Yes ☐ No
14. Have you ever had a heart attack or heart trouble? ☐ Yes ☐ No
15. Do you wear glasses or contact lenses? ☐ Yes ☐ No
16. Have you been under the care of a physician during the past year? ☐ Yes ☐ No
    If yes, for what condition? ______
17. Is there any change in your breathing since last year? ☐ Yes ☐ No
    If yes, how has it changed and do you know why? ______

Occupational and Social History

1. How long have you worked for your most recent employer? ______
2. What jobs have you held with this employer? Include job title and length of time in each job.
3. In each of these jobs, how many hours a day were you exposed to chemical or dust?
4. What chemicals have you worked with most of the time? ______
5. What personal protective gear was provided to you to protect you from exposure to these chemicals?
6. Do you wear the personal protective gear provided to you? ☐ Yes ☐ No
   If no, why not? ______
7. What job(s) did you have prior to the most recent job? Please list the approximate dates and any known exposures.

Employer	Dates	Exposures

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#:

8. In your work history, have you ever had exposure to:

Wood dust:	☐ Yes ☐ No	Cadmium:	☐ Yes ☐ No	Arsenic or asbestos:	☐ Yes ☐ No
Nickel:	☐ Yes ☐ No	Chromium:	☐ Yes ☐ No	Silica (foundry, sand blasting):	☐ Yes ☐ No
Lead:	☐ Yes ☐ No	Organic solvents:	☐ Yes ☐ No	Urethane foams:	☐ Yes ☐ No

9. Do you smoke? ☐ Yes ☐ No

If yes, how much and for how long?

Pipe: ______

Cigars: ______

Cigarettes: ______

Other: ______

10. Do you drink alcohol in any form? ☐ Yes ☐ No

If yes, how much, how long, and how often?

Liquor: ______

Beer: ______

Wine: ______

11. Are you exposed to any dust or chemicals at home? ☐ Yes ☐ No

If yes, please explain. What is the exposure, how much and for how long?

______

______

12. Do you have any hobbies or "side jobs" that require you to use chemicals such as: furniture stripping, sand blasting, insulation or manufacture of urethane foam, furniture, etc.? ☐ Yes ☐ No

If yes, please describe, giving type of business or hobby, chemicals used and length of exposure:

______

______

13. Do you get any physical exercise other than that required to do your job? ☐ Yes ☐ No

If yes, explain: ______

______

Symptoms Questionnaire

1. Do you ever have any shortness of breath? ☐ Yes ☐ No

If yes, do you have to rest after climbing several flights of stairs? ☐ Yes ☐ No

If yes, if you walk on the level with people your own age, do you walk slower then they do? ☐ Yes ☐ No

2. Do you cough frequently? ☐ Yes ☐ No

If yes, have you had this cough for more than two years? ☐ Yes ☐ No

If yes, please describe: ______

______

3. Do you cough as much as three months out of the year? ☐ Yes ☐ No

If yes, have you had this cough for more than two weeks? ☐ Yes ☐ No

If yes, do you ever cough anything up from your chest? ☐ Yes ☐ No

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#:

4. Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest? ☐ Yes ☐ No
   If yes, do you notice this on any particular day of week? ☐ Yes ☐ No
   If yes, do you notice that this occurs at any particular place? ☐ Yes ☐ No
   If yes, do you notice that this is worse after you have returned to work after being off for several days? ☐ Yes ☐ No
5. Have you ever noticed any wheezing in your chest? ☐ Yes ☐ No
   If yes, is this only with colds or other infections? ☐ Yes ☐ No
   Is this caused by exposure to any kind of dust or other material? ☐ Yes ☐ No
   If yes, what kind? ______________________
6. Have you noticed any burning, tearing, or redness of your eyes when you are at work? ☐ Yes ☐ No
   If yes, explain circumstances: ______________________
   ____
7. Have you noticed any sore or burning throat, or itchy or burning nose? ☐ Yes ☐ No
   If yes, please explain the circumstances: ______________________
   ____
8. Have you noticed any stuffiness or dryness of your nose? ☐ Yes ☐ No
9. Do you ever have swelling of the eyelids or face? ☐ Yes ☐ No
10. Have you ever been jaundiced? (yellowing of skin or eyes) ☐ Yes ☐ No
   If yes, was this accompanied by any pain? ☐ Yes ☐ No
11. Have you ever had a tendency to bruise easily or bleed excessively? ☐ Yes ☐ No
12. Do you have frequent headaches that are not relieved by aspirin or Tylenol? ☐ Yes ☐ No
   If yes, do they occur at any particular time of the day or week? ☐ Yes ☐ No
   If yes, when? ______________________
   ____
13. Do you have frequent episodes of nervousness or irritability? ☐ Yes ☐ No
14. Do you tend to have trouble concentrating or remembering? ☐ Yes ☐ No
15. Do you ever feel dizzy, light-headed, excessively drowsy or feel like you have been drugged? ☐ Yes ☐ No
16. Does your vision ever become blurred? ☐ Yes ☐ No
17. Do you have numbness or tingling of the hands or feet or other parts of your body? ☐ Yes ☐ No
18. Have you ever had chronic weakness or fatigue? ☐ Yes ☐ No
19. Have you ever had any swelling of your feet or ankles to the point where you could not wear your shoes? ☐ Yes ☐ No
20. Are you bothered by heartburn or indigestion? ☐ Yes ☐ No

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#:

21. Have you ever noticed any type of skin rash you feel was related to your work? ☐ Yes ☐ No
22. Do you ever have itching, dryness, or peeling and scaling of the hands? ☐ Yes ☐ No
23. Do you ever have a burning sensation in the hands, or reddening of the skin? ☐ Yes ☐ No
24. Do you ever have cracking or bleeding of the skin on your hands? ☐ Yes ☐ No
25. Have you ever been told that you have kidney or bladder problems? ☐ Yes ☐ No
26. Have you ever passed blood in your urine? ☐ Yes ☐ No
27. Do you have any physical complaints today? ☐ Yes ☐ No
    If yes, please explain: ______________________________
    ____
28. Do you have other health conditions not covered by these questions? ☐ Yes ☐ No
    If yes, please explain: ______________________________
    ____
    ____

I certify that I have answered these questions truthfully and to the best of my ability.

______________________________ _________/_________
Patient Signature Date / Time

______________________ ______________________ _________/_________
Reviewed by Print Name Reviewed by Signature Date / Time