



TODAY'S DATE

HEALTH SERVICES CENTER: K-25 ORNL PGDP PORTS Y-12 OTHER

IDENTIFICATION SECTION

NAME (LAST, FIRST, MIDDLE INITIAL)		BADGE NUMBER		HOME PHONE	
DATE OF BIRTH	AGE	SEX	MARITAL STATUS	ETHNIC ORIGIN	RACE
JOB TITLE			BUILDING	MAIL STOP	WORK PHONE
DIVISION NAME			ADMINISTRATIVE PLANT		
SUPERVISOR NAME			BUILDING	MAIL STOP	WORK PHONE

EMERGENCY CONTACTS

NAME	RELATIONSHIP	DAYTIME PHONE	EVENING PHONE	CELL\OTHER

EDUCATION SECTION (mark highest year completed)

Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12

	Year Completed	Degree(s) Awarded	Institution Name
Trade School	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
College	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		
Post Graduate	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		

PLEASE CHECK EITHER YES OR NO WHERE APPLICABLE ON ALL THE FOLLOWING PAGES.

PERSONAL MEDICAL HISTORY

Do you consider your health to be: Excellent Good Fair Poor

Do you wear any sort of medical identification? Yes No Explain:

Have you ever been hospitalized? Yes No If yes, reason:

List any serious illnesses, accidents, or injuries and year: (be brief) Year

Have you had any outpatient or inpatient diagnostic and/or treatment procedures? Yes No If yes, explain:

Name:	
Badge No:	Date:

Have you ever had surgery for: (Check applicable box and indicate year of the LATEST occurrence)

	Year		Year
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Eyes	_____
<input type="checkbox"/> Ulcers	_____	<input type="checkbox"/> Ears	_____
<input type="checkbox"/> Hernia	_____	<input type="checkbox"/> Tonsils	_____
<input type="checkbox"/> Hiatal Hernia	_____	<input type="checkbox"/> Nose (including sinuses)	_____
<input type="checkbox"/> Appendicitis	_____	<input type="checkbox"/> Larynx (vocal cords)	_____
<input type="checkbox"/> Gall Bladder Disease	_____	<input type="checkbox"/> Throat, head, or neck	_____
<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Lungs or Chest	_____
<input type="checkbox"/> Intestinal Polyps	_____	<input type="checkbox"/> Heart	_____
<input type="checkbox"/> Varicose Veins	_____	<input type="checkbox"/> Stomach	_____
<input type="checkbox"/> Obstruction of bowel (blockage)	_____	<input type="checkbox"/> Colon	_____
<input type="checkbox"/> Blood clots or blocked arteries, including those in neck	_____	<input type="checkbox"/> Rectum	_____
<input type="checkbox"/> Orthopedic conditions (bones, joints, etc.)	_____	<input type="checkbox"/> Kidneys	_____
FEMALE		<input type="checkbox"/> Bladder	_____
<input type="checkbox"/> Hysterectomy	_____	<input type="checkbox"/> Brain	_____
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Breast	_____
<input type="checkbox"/> D and C	_____	<input type="checkbox"/> Back or Spine	_____
<input type="checkbox"/> Tubes (including tubal ligations)	_____	<input type="checkbox"/> Other	If yes, describe: _____
<input type="checkbox"/> Ovaries	_____		_____
MALE			_____
<input type="checkbox"/> Vasectomy	_____		_____
<input type="checkbox"/> Prostate	_____		_____
<input type="checkbox"/> Penis	_____		_____
<input type="checkbox"/> Testicles	_____		_____

List any medications (prescribed and/or over-the-counter) you are currently taking:

Type	When did you start?
_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO ANY OF THE FOLLOWING (check applicable box)

<input type="checkbox"/> Pollens (such as hay fever)	<input type="checkbox"/> Serum/Blood Check	<input type="checkbox"/> Medications (List only if reactions)
<input type="checkbox"/> Animals	<input type="checkbox"/> Metals (such as nickel)	_____
<input type="checkbox"/> Insects	<input type="checkbox"/> Chemicals (such as TDI)	_____
<input type="checkbox"/> Plants	<input type="checkbox"/> Food/additives	_____
<input type="checkbox"/> Others		_____
_____		_____
_____		_____
Remarks		_____
_____		_____
_____		_____

Name:	
Badge No:	Date:

COMMUNICABLE DISEASES

Have you ever had or do you now have any of the following conditions?

- Yes No Chicken Pox
- Yes No Mumps
- Yes No Malaria
- Yes No Whooping Cough
- Yes No Diphtheria
- Yes No Influenza
- Yes No Tuberculosis
- Yes No Hepatitis/Yellow Jaundice
- Yes No Meningitis/Encephalitis
- Yes No Measles
- Yes No Smallpox
- Yes No Typhoid Fever
- Yes No Rheumatic Fever
- Yes No Shingles
- Yes No Poliomyelitis (Polio)
- Yes No Scarlet Fever
- Yes No Mononucleosis
- Yes No Sexually Transmitted Diseases _____
- Yes No Other _____
- Yes No Have you had a positive tuberculosis test?
- Yes No Have you lived with someone who had tuberculosis?

IMMUNIZATION HISTORY

Have you been immunized against the Following?
(Give dates if known.)

- Yes No Hepatitis B _____
- Yes No Rabies _____
- Yes No Rubella _____
- Yes No Measles _____
- Yes No Smallpox _____
- Yes No Polio _____
- Yes No Cholera _____
- Yes No Diphtheria _____
- Yes No Tetanus _____
- Yes No BCG _____
- Yes No Mumps _____
- Yes No Typhoid _____
- Yes No Yellow Fever _____
- Yes No Other _____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD SINCE YOUR LAST EXAMINATION ANY OF THE FOLLOWING?

- EYES**
- Yes No Wear glasses
 - Yes No Wear contacts
 - Yes No Infection
 - Yes No Injury
 - Yes No Double vision
 - Yes No Poor vision
 - Yes No Cataracts
 - Yes No Glaucoma
 - Yes No Color Blindness
 - Yes No Pain
 - Yes No Worked with lasers
 - Yes No Viewed a solar eclipse directly
 - Yes No Other _____
- Remarks: _____

- EARS**
- Yes No Wear hearing aid
 - Yes No Drainage
 - Yes No Noises, ringing
 - Yes No Ear infection/ache
 - Yes No Ear injury
 - Yes No Trouble with hearing
 - Yes No Hole in ear drum
 - Yes No Pressure in ears
 - Yes No Excessive wax
 - Yes No Other _____
- Remarks: _____

- NOSE AND SINUSES**
- Yes No Polyps
 - Yes No Sinus trouble
 - Yes No Septal perforation
 - Yes No Difficulty breathing through nose
 - Yes No Problems with sense of smell or taste
 - Yes No Chronic congestion
 - Yes No Frequent nose bleeds
 - Yes No Other _____
- Remarks: _____

Name: _____	
Badge No: _____	Date: _____

MOUTH

- Yes No Trouble with teeth
 - Yes No Trouble with gums
 - Yes No Trouble with tongue
 - Yes No Trouble with jaw joints (TMJ)
 - Yes No Dentures
 - Yes No Infections or mouth sores
 - Yes No Salivary glands problem
 - Yes No Other _____
- Remarks: _____

THROAT

- Yes No Trouble swallowing
 - Yes No Persistent or recurrent hoarseness
 - Yes No Frequent sore throat
 - Yes No Other _____
- Remarks: _____

NECK

- Yes No Pain
 - Yes No Swelling or lumps
 - Yes No Stiffness
 - Yes No Other _____
- Remarks: _____

RESPIRATORY

- Yes No Shortness of breath
 - Yes No Asthma
 - Yes No Emphysema
 - Yes No Collapsed Lung
 - Yes No Recurrent or persistent cough
 - Yes No Recurrent or chronic bronchitis
 - Yes No Cough or spit up blood
 - Yes No Cough producing sputum (phlegm). How much? _____ (TBS/Day)
 - Yes No Pleurisy (grippe)
 - Yes No Pneumonia
 - Yes No Frequent colds
 - Yes No Other _____
- Have you ever used a respirator? Yes No
- If yes, any difficulties and why: _____
- Remarks: _____

CARDIOVASCULAR

- Yes No Heart trouble
 - Yes No High blood pressure
 - Yes No Heart attack
 - Yes No Heart murmur
 - Yes No Chest pain or tightness
 - Yes No Rheumatic fever
 - Yes No Heart valve problems
 - Yes No Chronic or recurrent swollen feet or ankles
 - Yes No Varicose veins
 - Yes No Blood clot/phlebitis
 - Yes No Leg pain with walking
 - Yes No Rapid pulse/fast heart rate
 - Yes No Palpitations or skipped beats
 - Yes No Other _____
- Abnormal cardiogram? Yes No
- Remarks: _____

BREAST (MALE AND FEMALE)

- Yes No Breast lump
 - Yes No Abnormal enlargement
 - Yes No Nipple discharge or bleeding
 - Yes No Surgery or biopsy
 - Yes No Ever had mammogram:
Date of last: _____
Result: _____
 - Yes No Other _____
- Remarks: _____

DIGESTIVE

- Yes No Stomach trouble
 - Yes No Ulcer
 - Yes No Indigestion/heart burn
 - Yes No Hiatal hernia
 - Yes No Liver trouble
 - Yes No Gall bladder trouble
 - Yes No Cirrhosis
 - Yes No Jaundice
 - Yes No Hepatitis
 - Yes No Colon disease
 - Yes No Other _____
- Yes No Chronic constipation
 - Yes No Chronic or recurrent diarrhea
 - Yes No Rectal problems/hemorrhoids
 - Yes No Intestinal/colon problems
 - Yes No Black or bloody stool
 - Yes No Inguinal or abdominal hernia (rupture)
 - Yes No Persistent or recurrent nausea/vomiting
 - Yes No Vomited Blood
 - Yes No Recurrent abdominal pain
 - Yes No Intestinal bleeding
- Remarks: _____

Name: _____	
Badge No: _____	Date: _____

URINARY

- Yes No Kidney stones
- Yes No Blood or pus in urine
- Yes No Kidney/bladder infection
- Yes No Painful/burning urination
- Yes No Get up more than once at night to urinate
- Yes No Trouble starting or stopping urination
- Yes No Nephritis
- Yes No Sugar or protein in urine
- Yes No Frequent urination
- Yes No Other _____

Remarks: _____

MALE GENITAL

- Yes No Prostate trouble
- Yes No Penis trouble
- Yes No Penile discharge
- Yes No Lumps or enlargement of testicles or scrotum
- Yes No Pain
- Yes No Sexual difficulty
- Yes No Other _____

Remarks: _____

FEMALE GENITAL

Onset of menstruation before age 17 after age 17
 Frequency of periods: _____
 Duration of periods: _____
 Date of last period: _____ OR Age at menopause _____
 Date of last pap smear: _____

- Yes No Heavy bleeding
- Yes No Bleeding or spotting between periods
- Yes No Post-menopausal bleeding
- Yes No Treated for female disorder
- Yes No Persistent or recurrent vaginal infection
- Yes No Persistent or recurrent pelvic infection (PID)
- Yes No Problem with ovaries/tubes/uterus
- Yes No Abnormal pap smear When? _____
- Yes No Have taken birth control pills
- Yes No Currently taking birth control pills
- Yes No Had hysterectomy/other surgery (such as D&C)
- Yes No Pain
- Yes No Unusual discharge
- Yes No Sexual difficulty
- Yes No Other _____

Remarks: _____

REPRODUCTIVE (MALE AND FEMALE)

The following items apply to both you and your spouse (current and past)
 How many pregnancies? _____
 How many children born? _____
 How many miscarriages/abortions/still births? _____
 Children have any major birth defects? Yes No
 If yes, explain: _____
 Have you ever taken fertility drugs? Yes No
 Remarks: _____

MUSCULOSKELETAL

- Yes No Joint problems
- Yes No Arthritis
- Yes No Rheumatism
- Yes No Gout
- Yes No Broken bones
- Yes No Bone problems
- Yes No Muscle problems
- Yes No Injury to neck/spine
- Yes No Lost work due to back trouble
- Yes No Back pain
- Yes No Back injury
- Yes No Hand/wrist problems
- Yes No Knee problems
- Yes No Foot problems
- Yes No Back trouble
- Yes No Loss of limbs/fingers/toes
- Yes No Ruptured disk
- Yes No Other _____

Remarks: _____

SKIN

- Yes No Growths Yes No Psoriasis
- Yes No Rashes Yes No Eczema
- Yes No Sores Yes No Significant scar
- Yes No Chronic or recurrent itching Yes No Tattoos
- Yes No Cancer: Type: _____
- Yes No Ever had a change in appearance of mole
- Yes No Other _____

Remarks: _____

Name:	
Badge No:	Date:

NEUROLOGICAL

<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No Neuritis	<input type="checkbox"/> Yes <input type="checkbox"/> No Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No Loss of memory	<input type="checkbox"/> Yes <input type="checkbox"/> No Minor or temporary stroke (TIA)
<input type="checkbox"/> Yes <input type="checkbox"/> No Speech difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No Head injury	<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness
<input type="checkbox"/> Yes <input type="checkbox"/> No Temporary paralysis or weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent or severe headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy
<input type="checkbox"/> Yes <input type="checkbox"/> No Permanent paralysis or weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No Shaking or tremor	<input type="checkbox"/> Yes <input type="checkbox"/> No Sciatica
<input type="checkbox"/> Yes <input type="checkbox"/> No Other _____	Remarks: _____	

PSYCHOLOGICAL

Yes No Anxiety

Yes No Depression

Yes No Insomnia (trouble sleeping)

Yes No History of nervous breakdown

Yes No Attempted suicide

Yes No Counseling or treatment

Yes No Nervousness or emotional problems

Yes No Fears or phobias (such as claustrophobia-fear of confined spaces)

If yes, explain: _____

Yes No Other _____

Remarks: _____

ENDOCRINE

Yes No Recent, significant weight change

Yes No Significant increase in thirst

Yes No Unexplained sleepiness or drowsiness

Yes No Intolerance to cold

Yes No Intolerance to heat

Yes No Underactive thyroid

Yes No Overactive thyroid

Yes No Goiter

Yes No Thyroid trouble

Yes No Diabetes

Yes No Other glandular problems

Yes No Other _____

Remarks: _____

BLOOD

Yes No Anemia

Yes No Blood too thin

Yes No Blood too thick

Yes No Leukemia

Yes No Bleed or bruise easily

Yes No Other _____

Remarks: _____

GENERAL

Yes No Night sweats Yes No Other _____

Yes No Dizziness _____

Yes No Unusual fatigue _____

Yes No Tumor, growth, or cyst _____

Yes No Cancer (any type) _____

Yes No Frostbite _____

Yes No Heat exhaustion or heat stroke _____

Remarks: _____

Have you had any health problems not previously mentioned? Yes No

Have you been refused or lost employment because of health problems? If yes, explain: Yes No

Have you been refused as a blood donor? If yes, explain: Yes No

Have you ever been rated up or rejected for insurance? If yes, explain: Yes No

Have you been rejected by or had a medical discharge from the military? If yes, explain: Yes No

Have you had disability compensation? If yes, explain: Yes No

Has a physician restricted your work or physical activities from medical reasons? If yes, explain: Yes No

Have you applied for Workers' Compensation? If yes, explain: Yes No

Do you consider yourself to be handicapped? If yes explain: Yes No

Name:	
Badge No:	Date:

LIFESTYLE/HOBBIES

TOBACCO USE

Have you ever used a tobacco product of any kind?
(if no skip to next section, ALCOHOL USE) Yes No

Have you ever smoked? Yes No

If yes..... Cigarettes?

Pipe?

Cigars?

Do you smoke now Yes No

Age first started smoking _____

Age last stopped smoking _____

If you now smoke, or have smoked in the past, please check the appropriate response indicating DAILY USAGE:

Cigarettes: Less than 1 pack 1-2 packs 2 or more packs

Cigars: 1-2 3-6 7 or more

Pipe: 1-2 bowls 3-6 bowls 7 or more bowls

Have you ever used smokeless tobacco products in any form (snuff, chewing, etc.)? Yes No

If yes, Age first started using _____

Do you use smokeless tobacco products now?..... Yes No

If no, age when stoppped using..... _____

..... Number of cans, plugs, twists per week _____

ALCOHOL USE

Do you drink or have you ever drunk alcoholic beverages? (If no, skip to next section DIET) Yes No

Do you drink alcoholic beverages now? Yes No

Have you ever had a drinking problem? Yes No

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever been annoyed by criticism of your drinking? Yes No

Have you ever felt guilty about your drinking? Yes No

Have you ever felt the need for an eye-opener in the morning? Yes No

If you drink, or have in the past, please check the appropriate response indicating DAILY consumption:

Liquor: Occasional 1 2 3 4 or more

Beer: Occasional 1 2 3 4 or more (can)

Wine and coolers: Occasional 1 2 3 4 or more (glass)

DIET

Is your diet: high in fiber	<input type="checkbox"/> Yes	<input type="checkbox"/> No
low in fat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
low in salt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
moderate in calories	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you on a special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain: _____		

EXERCISE

Do you have a regular exercise program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain: _____		

OTHER

How many cups of coffee or other caffeine-containing drinks do you consume per day? _____		
What are your hobbies or recreational activities? _____		
Have you ever used illegal drugs, used prescription drugs illegally, or have you been addicted to any drug? If yes, explain: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name:	
Badge No:	Date:

OCCUPATIONAL/EXPOSURE HISTORY

Please fill in the table below listing all jobs you have worked, including short-term, seasonal, part-time and military.
START WITH YOUR MOST RECENT JOB and complete in reverse chronological order.

EMPLOYER NAME / LOCATION	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	P A R T	F U L L	INDUSTRY TYPE (DESCRIBE)	JOB DUTIES (DESCRIBE)	KNOWN HEALTH HAZARDS (Dusts, Solvents, Noise, etc.)	PROTECTIVE EQUIP. USED (Ear Plugs, Muffs, Gloves, etc.)	Ever off work for health/injury?	
									YES	NO
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
	FROM MO: ____ YR: ____	TO MO: ____ YR: ____	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>

Name:	
Badge No:	Date:

DO YOU THINK YOU HAVE HAD EXPOSURE TO ANY OF THE FOLLOWING?
(Check work and/or other, such as home, recreational, etc.)

SUBSTANCE	WORK	OTHER	SUBSTANCE	WORK	OTHER
Acrylonitrile	<input type="checkbox"/>	<input type="checkbox"/>	Hydrazine	<input type="checkbox"/>	<input type="checkbox"/>
Arsenic	<input type="checkbox"/>	<input type="checkbox"/>	Isocyanates (TDI)	<input type="checkbox"/>	<input type="checkbox"/>
Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	Lasers	<input type="checkbox"/>	<input type="checkbox"/>
Benzene	<input type="checkbox"/>	<input type="checkbox"/>	Metals (lead, mercury, nickel)	<input type="checkbox"/>	<input type="checkbox"/>
Beryllium	<input type="checkbox"/>	<input type="checkbox"/>	Methylene Chloride	<input type="checkbox"/>	<input type="checkbox"/>
Cadmium	<input type="checkbox"/>	<input type="checkbox"/>	Microwaves (radar)	<input type="checkbox"/>	<input type="checkbox"/>
Carbon Disulfide	<input type="checkbox"/>	<input type="checkbox"/>	Noise, Loud	<input type="checkbox"/>	<input type="checkbox"/>
Carbon Tetrachloride	<input type="checkbox"/>	<input type="checkbox"/>	Oxides of Nitrogen	<input type="checkbox"/>	<input type="checkbox"/>
Carbon Monoxide	<input type="checkbox"/>	<input type="checkbox"/>	Paints	<input type="checkbox"/>	<input type="checkbox"/>
Chlorine	<input type="checkbox"/>	<input type="checkbox"/>	Pesticides/Herbicides	<input type="checkbox"/>	<input type="checkbox"/>
Chloroform	<input type="checkbox"/>	<input type="checkbox"/>	Phenols	<input type="checkbox"/>	<input type="checkbox"/>
Chloroprene	<input type="checkbox"/>	<input type="checkbox"/>	Phosgene	<input type="checkbox"/>	<input type="checkbox"/>
Chromate	<input type="checkbox"/>	<input type="checkbox"/>	Plutonium/Transplutronics	<input type="checkbox"/>	<input type="checkbox"/>
Chromic Acid Mist	<input type="checkbox"/>	<input type="checkbox"/>	Radiation (Ionizing)	<input type="checkbox"/>	<input type="checkbox"/>
Coal Tar Products	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive Movement/Vibration	<input type="checkbox"/>	<input type="checkbox"/>
Cutting Oils	<input type="checkbox"/>	<input type="checkbox"/>	Silica	<input type="checkbox"/>	<input type="checkbox"/>
Degreasers/Solvents	<input type="checkbox"/>	<input type="checkbox"/>	Trichloroethylene	<input type="checkbox"/>	<input type="checkbox"/>
Dusts (wood, coal, grain, cotton, stone, fibers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Uranium/Transuranics	<input type="checkbox"/>	<input type="checkbox"/>
Engine Exhaust	<input type="checkbox"/>	<input type="checkbox"/>	Vanadium	<input type="checkbox"/>	<input type="checkbox"/>
Epoxies	<input type="checkbox"/>	<input type="checkbox"/>	Vinyl Chloride	<input type="checkbox"/>	<input type="checkbox"/>
Fluorine	<input type="checkbox"/>	<input type="checkbox"/>	Welding Fumes	<input type="checkbox"/>	<input type="checkbox"/>
Formaldehyde	<input type="checkbox"/>	<input type="checkbox"/>	Other (List):	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY REVIEWED BY:

RN/MD/PA/FNP

Staff Code

Date