KAISER PERMANENTE

Kaiser on the Job

MEDTRONIC Chemical Exposure History

Name: ______________________ Date: ______________________

Kaiser #: ______________________ Birthdate: ______________ Age: ________

Home Address: ______________________ Daytime Telephone: ______________________

______________________ Employee Number: ______________________

Department: ______________________ Cost Center Number: ______________________

Statement of confidentiality: This health history is designed to be reviewed by Kaiser Permanente employees or their representatives only. It will be part of a medical record in no way connected to Medtronic personnel files.

Work History - Have you:

Yes	No	
☐	☐	Worked around material which you consider hazardous?
☐	☐	Served on a HAZMAT (Hazardous Material) team?
☐	☐	Worked in a position requiring hearing protection?
☐	☐	Worked in a very dusty environment?
☐	☐	Worked in a position requiring respiratory protection?
☐	☐	Had a work-related injury/illness needing treatment or causing lost work time?
☐	☐	Been found to have a disability as a result of a work-related illness/injury?

If any of the above is answered "YES", please explain: ______________________

Personal Health History

Name of personal physician or clinic (include town and state) ______________________

Have you seen a physician in the last 12 months? ☐ Yes ☐ No

If so, for what reason: ______________________

Medications (prescription, non-prescription, dietary supplements, herbal remedies, etc.) you are currently taking.

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Surgery Have you had any? Please specify:

Type of Surgery	Date

Major medical problems Please list the conditions you currently consult with a physician about.

____

Additional active health issue Please list those conditions for which you consult other health practitioners providers of complementary
care or counselors: ____

____

Have you ever been hospitalized (other than for surgery)? Please specify:

Reason for Hospitalization	Hospital	Date

Do you smoke? ☐ Yes ☐ No
If yes: Number per day ______________
How many years ______________

If no: Have you ever smoked? ☐ Yes ☐ No
When did you quit? ______________
How many years did you smoke? ______________
How many cigarettes per day on average? ______________

Do you drink alcohol? ☐ Yes ☐ No
If yes:
☐ less than one drink a week
☐ one to 13 drinks a week (under 2/day)
☐ 13 to 25 drinks a week (2 to 5/day)
☐ over 35 a week (over 5/day)

If no: Did you drink in the past? ☐ Yes ☐ No
Specify: ____

GENERAL HEALTH HISTORY

		Have now	In past not now	Never had
	Skin	☐	☐	☐
1.	Acne	☐	☐	☐
2.	Eczema	☐	☐	☐
3.	Psoriasis	☐	☐	☐
4.	Sensitive skin/skin allergy	☐	☐	☐
5.	Skin cancer	☐	☐	☐
	Allergy			
6.	Allergy to chemicals ______________	☐	☐	☐
7.	Bee sting allergy	☐	☐	☐
8.	Food allergy ______________________	☐	☐	☐
9.	Hay fever	☐	☐	☐
10.	Medication allergy_________________	☐	☐	☐
11.	Latex sensitivity			
	Bone, Joint, Muscle			
12.	Bone cancer	☐	☐	☐
13.	Bone infection	☐	☐	☐
14.	Muscle weakness	☐	☐	☐
15.	Painful joints/arthritis	☐	☐	☐

		Have now	In past not now	Never had
	Lung, Breathing	☐	☐	☐
16.	Asthma	☐	☐	☐
17.	Difficulty using respiratory protection equipment	☐	☐	☐
18.	Emphysema	☐	☐	☐
19.	Unusual shortness of breath of coughing	☐	☐	☐
20.	Work-related lung damage	☐	☐	☐
21.	Other lung conditions	☐	☐	☐
	Sensory			
22.	Wear glasses of contacts	☐	☐	☐
23.	Any vision problems	☐	☐	☐
24.	Hard of hearing/deafness	☐	☐	☐
25.	Poor or absent sense of smell	☐	☐	☐
26.	Poor or absent sense of taste	☐	☐	☐
	Emotional, Psychiatric			
27.	“Nervous breakdown: requiring hospitalization	☐	☐	☐
28.	Schizophrenia	☐	☐	☐

General Health History, cont'd

		Have now	In past not now	Never had
	EmotionalL, Psychiatric cont'd			
29.	Manic-depressive illness	☐	☐	☐
30.	Phobias requiring treatment or limiting activity	☐	☐	☐
31.	Alcohol/drug abuse	☐	☐	☐
32.	Alcohol/drug dependency treatment	☐	☐	☐
33.	Depression	☐	☐	☐
34.	Treatment for anxiety	☐	☐	☐
	Heart			
35.	High blood pressure	☐	☐	☐
36.	Chest pain	☐	☐	☐
37.	Heart attack	☐	☐	☐
38.	Heart murmur	☐	☐	☐
		☐	☐	☐
39.	Heart surgery			
40.	Heart rhythm disturbance (irregular pulse)	☐	☐	☐
	Digestive			
41.	Ulcer	☐	☐	☐
42.	Unusual abdominal pain	☐	☐	☐
43.	Unusual or chronic diarrhea	☐	☐	☐
44.	Unusual or chronic constipation	☐	☐	☐
45.	Blood in stools	☐	☐	☐
	Nerve, Brain			
46.	Blackouts	☐	☐	☐
47.	Brain tumor	☐	☐	☐
48.	Cerebral palsy	☐	☐	☐
49.	Difficulty concentrating	☐	☐	☐
50.	Dizzy spells	☐	☐	☐
51.	Unusual or frequent headaches	☐	☐	☐
52.	Memory loss	☐	☐	☐
53.	Multiple sclerosis	☐	☐	☐
54.	Unusual numbness	☐	☐	☐
55.	Parkinson's disease	☐	☐	☐
56.	Seizures, epilepsy	☐	☐	☐
57.	Stroke	☐	☐	☐
58.	Muscle weakness	☐	☐	☐
	Blood			
59.	Anemia (low blood count)	☐	☐	☐
60.	Excessive bleeding after surgery or injury	☐	☐	☐
61.	Women-excessive/irregular menstrual bleeding	☐	☐	☐

		Have now	In past not now	Never had
	Blood, cont'd			
62.	Hemophilia	☐	☐	☐
63.	Spontaneous bleeding	☐	☐	☐
64.	Leukemia/Lymphoma	☐	☐	☐
65.	Blood clots, thrombophlebitis	☐	☐	☐
	Cancer			
66.	Cancer other than skin	☐	☐	☐
67.	Radiation therapy	☐	☐	☐
68.	Chemotherapy	☐	☐	☐
	Liver			
69.	Hepatitis/jaundice	☐	☐	☐
70.	Cirrhosis	☐	☐	☐
71.	Enlarged liver	☐	☐	☐
72.	Gallbladder disease	☐	☐	☐
73.	Liver dysfunction	☐	☐	☐
	Enodocrine Glands			
74.	Diabetes	☐	☐	☐
75.	Thyroid problems	☐	☐	☐
76.	Other gland problem (adrenal,	☐	☐	☐
	Pituitary, pancreas, parathyroid,	☐	☐	☐
	Ovary, testicle)	☐	☐	☐
	Kidney, Bladder			
77.	Kidney stones	☐	☐	☐
78.	Urine infections, more than three	☐	☐	☐
79.	Kidney failure or insufficiency	☐	☐	☐
80.	Blood in urine	☐	☐	☐
	Reproductive			
81.	Infertility	☐	☐	☐
82.	Sterility	☐	☐	☐
83.	Tubal ligation	☐	☐	☐
84.	Vasectomy	☐	☐	☐
85.	Difficulty becoming pregnant	☐	☐	☐
86.	Other reproductive issues	☐	☐	☐
	Other			
87.	Unplanned weight loss	☐	☐	☐
88.	Fever, chills, sweating (other than with known infection)	☐	☐	☐
89.	Claustrophobia	☐	☐	☐

Please explain in detail all numbers answered as yes. Ask for extra paper if necessary.

I certify that the information provided by me on this questionnaire is complete and true to the best of my knowledge.

Signature: ______________________________ Date: ______________________________

Thank you for the time taken to fully complete this medical history.
Kaiser Permanente, Kaiser On-The-Job

For Nurse or Physician Use:

North Memorial Clinic Personnel Signature: ______________________________ Date: ______________