

OCCUPATIONAL & ENVIRONMENTAL MEDICINE CLINIC
YALE UNIVERSITY SCHOOL OF MEDICINE
135 COLLEGE STREET, ROOM 392
NEW HAVEN, CT 06510-2483

HEALTH & EXPOSURE QUESTIONNAIRE

The purpose of this questionnaire is to provide us with information regarding your work and medical history to help us be of greater service to you. Should you feel uncomfortable answering any of the questions, please feel free to skip them.

Date: _____

PERSONAL INFORMATION:

Name: Last _____ First _____ Middle Initial _____
Date of Birth: _____ Present Age: _____ Social Security #: _____
Address: Street _____
City _____ State _____ Zip Code _____
Home Telephone _____

REFERRAL INFORMATION: Who referred you to this clinic? (Check one)

_____ Self
_____ Physician: Name _____
_____ Attorney: Name _____
_____ Union Representative
_____ Employer
_____ Other: _____

WHAT IS YOUR REASON FOR COMING TO THIS CLINIC?

Please list any toxic substances you have been exposed to that may have contributed to your present illness, as well as the location where you were exposed and the dates of exposure. If you are unable to name the substance, describe it as best you can. For example: "degreasing solvent", "welding fumes".

Toxic Substance	Location of Exposure (workplace, home, etc.)	Dates of Exposure

LEGAL INFORMATION:

The following questions are included because it is helpful for us to know about your Workers' Compensation status. If, however, you prefer not to answer them, please skip to the next section. Your decision to not answer these questions will in no way effect the service you receive from this clinic or your compensation status.

Have you filed for Workers' Compensation for the problem bringing you to this clinic? _____
 If yes, have you received any compensation yet? _____

Are you represented by an attorney? _____
 If yes, please advise your attorney's name and address: _____

MEDICAL HISTORY:

List any medical conditions you have. Place a check next to any which may have been caused by work:

CONDITION:	CAUSED BY WORK?

Do you have a regular or family medical doctor? _____

If yes, please advise his/her name and address:

Are there any other doctors presently treating you? _____

If yes, please advise their names and addresses:

Are you presently taking any medications? _____

If yes, please list them:

Have you ever been hospitalized? _____

If yes, please list:

HOSPITAL	DATE	REASON

Have you ever smoked cigarettes regularly? _____

If yes, do you still smoke? _____

If no, when did you quit? _____

For how many years have you, or did you, smoke? _____ yrs.

On the average, how many packs per day do you, or did you, smoke? _____ packs per day

Have you ever smoked cigars or a pipe regularly? _____

Have you ever been a regular consumer of beer or other alcohol? _____

Please indicate if you have suffered any of the symptoms listed below and the frequency of these symptoms. If possible, please advise the month and year when symptoms first appeared.

SYMPTOM	RARE	OCCASIONAL	REGULAR	DATE SYMPTOM FIRST APPEARED
COUGH				
WHEEZING				
SHORTNESS OF BREATH				
CHEST PAIN OR TIGHTNESS				
PALPITATIONS OR IRREGULAR HEART BEAT				
SWELLING OF THE LEGS				
SORE EYES, NOSE OR THROAT				
HOARSENESS				
SKIN RASH				
HEADACHE				
LOSS OF MEMORY				
ANXIETY OR DEPRESSION				
IRRITABILITY				
DIZZINESS				
WEAKNESS				
NUMBNESS OF HANDS OR FEET				
UNCOORDINATION OR CLUMSINESS				
FATIGUE OR TIREDNESS				
BACKACHE				
PAIN IN OTHER JOINTS				
PAINFUL HANDS IN COLD WEATHER				
STOMACH ACHE OR HEARTBURN				
YELLOW JAUNDICE				
DIARRHEA				
CONSTIPATION				
BLOOD IN STOOL				
FREQUENT URINATION				
DIFFICULTY WITH URINATION				
DARK URINE				
LOSS OF SEXUAL INTEREST				
IMPOTENCE OR LOSS OF SEXUAL FUNCTION				
IRREGULAR MENSTRUAL PERIODS				
INFERTILITY/DIFFICULTY HAVING CHILDREN				
LOSS OF APPETITE				
FEVERS				
OTHER:				