UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER

OCCUPATIONAL HEALTH HISTORY FORM

Name: _____ University ID #: _____ Date: _____

Supervisor name: _____ Department: _____ Contact #: _____

Drug allergies (list name and reaction): _____

Medications (prescription, over-the-counter): _____

We ask these questions to prepare to take the best, most inclusive care of you!

Gender assigned at birth: □ Male □ Female □ Decline to answer

Current gender identity: □ Male □ Female □ FTM/Transman □ MTF/Transwoman □ Gender queer
□ Something else □ Decline to answer

PERSONAL HISTORY

Problem	Yes	No	Unsure	Please explain if you answered "yes"
Headaches/Migraines/Epilepsy/Seizures	□	□	□	
Lung Disease (Asthma, Tuberculosis, etc.)	□	□	□	
Heart Disease (High Blood Pressure, Murmurs, etc.)	□	□	□	
High Cholesterol	□	□	□	
Stroke/Blood Clots	□	□	□	
Stomach or Intestinal Problems (Reflux, Crohn's disease, Gluten/Lactose intolerance, Irritable bowel, etc.)	□	□	□	
Liver Disease (Mononucleosis, Hepatitis, Jaundice, etc.)	□	□	□	
Gallbladder Disease	□	□	□	
Urinary Problems (Infections, Kidney Stones, etc.)	□	□	□	
Joint, Muscle or Bone (Scoliosis, Fractures, etc.)	□	□	□	
Blood Problems (Anemia, Clotting, Sickle Cell, etc.)	□	□	□	
Endocrine Problems (Diabetes, Thyroid, PCOS, etc.)	□	□	□	
Skin/Hair Problems (Acne, Rashes, etc.)	□	□	□	
Cancer (specify type)	□	□	□	
Birth Defects/Disabilities	□	□	□	
Mental/Behavioral (Depression, Anxiety, ADHD, etc.)	□	□	□	
Other illnesses/injuries	□	□	□	
Surgery (Tonsils, Wisdom Teeth, Appendix, Hernia, etc.)	□	□	□	
Hospitalization (admitted overnight)	□	□	□	

FAMILY HISTORY □ Adopted

Problem	Yes	No	Unsure	Please list which family members (father, mother, siblings, grandparents, etc.)
Lung Disease (Asthma, Tuberculosis, etc.)	□	□	□	
Heart Disease (High Blood Pressure, Murmurs, etc.)	□	□	□	
Heart Attack BEFORE age 50	□	□	□	
High Cholesterol	□	□	□	
Stroke/Blood Clots	□	□	□	
Diabetes	□	□	□	
Thyroid Disease	□	□	□	
Breast Cancer	□	□	□	
Other Cancer(s) (specify type)	□	□	□	
Mental/Behavioral (Depression, Anxiety, ADHD, etc.)	□	□	□	
Other illnesses	□	□	□	

PLEASE COMPLETE THE REVERSE SIDE

SOCIAL HISTORY

	Yes	No	What type?	How often?
Do you use tobacco?	□	□		
Do you drink alcohol?	□	□		
Do you regularly use any recreational drugs (Marijuana, Cocaine, Heroin, LSD, Shrooms, Ecstasy, etc.)?	□	□		
Do you regularly use any prescription drugs that is not prescribed to you (Adderall, Ritalin, opiates, benzos, etc.)?	□	□		

OCCUPATIONAL HEALTH HISTORY

Do you know or have you ever worked with any of the following agents/hazards?	Yes	No	Please explain if you answered "yes". State when you last worked with the agent and how long.
Asbestos	□	□	
Biological agents/hazards (Type_____)	□	□	
Excessive heat	□	□	
Excessive noise	□	□	
Exhaust	□	□	
Formaldehyde	□	□	
Pesticides	□	□	
Radioactive material solvents (Type _____)	□	□	