HEALTH HISTORY

(Reference MNL-293131)

Instructions - PLEASE:

- **Print or type clearly.**
- **Read CAREFULLY and complete the whole form unless otherwise instructed.**

Name: _____ **Badge#:** _____

Date of Birth: _____ **Dept. #** ***(if known):*** _____ **Plant Phone#** ***(if known):*** _____

In your own words, how is your current health?

_____

List any medications, chemicals, or substances ***(excluding food and animals)*** **you are allergic/sensitive to:**

_____

Give approximate date of last tetanus toxoid: _____

Did you have any reaction from the injection; if yes, what? _____

Who is your primary care doctor? _____

List other doctors ***(such as cardiologist, urologist, etc.)*** **you see regularly:**

_____

List all visits to health care providers (*doctors, nurses, dentists, etc.)* in the past year:

_____

Have you been treated for any chronic or serious illnesses? ☐ **No** ☐ **Yes –** ***If YES, for what condition?***

_____

Has your work been changed or modified because of your health? ☐ **No** ☐ **Yes –** ***If YES, list changes:***

_____

_____

Controlled By: Environment Safety & Health
POC: Alex Saldivar, alex.saldivar@pantex.doe.gov
Pantex eDC/RO ID: 974083
Date Reviewed: 4/15/2026

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List any operations or surgeries, reason and approximate date:

Type of Operation	Reason for Operation (*condition/disease*)	Date

List dates of treatments or referrals for a mental or emotional disorder and treating physician, counselor, or therapist *(care provider name)*:

Disorder	Care Provider	Treated from/to
		-
		-
		-

TOBACCO, ALCOHOL, DRUG HISTORY

Have you ever smoked? ☐ **Yes** ☐ **No** Year started _____

Do you currently smoke? ☐ **Yes** ☐ **No**

How many cigarettes do/did you now smoke per day? ___

How many cigars do/did you smoke per day? ___

How many pipes do/did you smoke per day? ___

How many times do you use any other smoking device (i.e., vape, dap pen, etc)? ___

Do you use smokeless tobacco? ☐ **Yes** ☐ **No** If YES, how many dips/tins/pouches per day? ___

Have you ever contemplated or attempted suicide?	☐ **Yes** ☐ **No**
Have you ever felt that you should cut down on your drinking?	☐ **Yes** ☐ **No**
Have people annoyed you by criticizing your drinking?	☐ **Yes** ☐ **No**
Have you ever felt bad or guilty about your drinking?	☐ **Yes** ☐ **No**
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover *(eye opener)*?	☐ **Yes** ☐ **No**
How many beers do you drink in an average week?	**bottles/cans**
How many glasses of wine do you drink in an average week?	**glasses**
How many shots *(1.5 ounces)* of hard liquor do you drink in an average week?	**shots**
Do you currently abuse drugs and/or alcohol?	☐ **Yes** ☐ **No**
Are you now or have you ever been under treatment for drug or alcohol abuse?	☐ **Yes** ☐ **No**

If yes, give date and circumstances:

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VISION: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Wear glasses or contacts
- ☐ Color blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Serious Eye Injury. Date? _____
- ☐ Double vision
- ☐ Persistent eye pain
- ☐ RK, PRK, or LASER surgery. Date? _____

EARS, NOSE, AND THROAT: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Ruptured ear-drum
- ☐ Defective hearing
- ☐ Serious ear injury. Date? _____
- ☐ Frequent or severe earaches
- ☐ Discharge from your ears
- ☐ Hear ringing noises
- ☐ Wearing a hearing aid
- ☐ Severe or frequent nosebleeds
- ☐ Heavy bleeding after tooth extraction
- ☐ Persistent hoarseness
- ☐ Trouble swallowing liquids
- ☐ Trouble swallowing solid foods
- ☐ Mouth/tongue sores that do not heal
- ☐ Excessive snoring or Sleep Apnea

NEUROLOGICAL: DO YOU CURRENTLY HAVE OR HAVE EVER YOU HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Migraine headaches
- ☐ Sinus headaches
- ☐ Headaches affecting vision
- ☐ Severe headaches not relieved by aspirin
- ☐ Frequent dizzy spells
- ☐ Numbness or tingling sensations of the hands
- ☐ Numbness of the feet
- ☐ Convulsions or epileptic seizures

HEALTH HISTORY

(Reference MNL-293131)

NEUROLOGICAL *(continued...)*: DO YOU CURRENTLY HAVE OR HAVE EVER YOU HAD ANY OF THE FOLLOWING? *Check ALL that apply and explain any responses.*

- ☐ Fainting spells or blackouts
- ☐ Stroke, Transient ischemic attack *(TIA),* or brain attack
- ☐ Frequent weakness or paralysis in arms or legs
- ☐ Period of unconsciousness, lasting more than 5 minutes, due to head injury or blow to the head
- ☐ Concussion or head injury
- ☐ Frequent memory loss or periods of amnesia
- ☐ Periods of difficulty with speech
- ☐ Frequent periods of severe anxiety or tension
- ☐ Frequent periods of severe depression
- ☐ Taking tranquilizers
- ☐ Taking anti-anxiety medication
- ☐ Taking anti-depressant medication

CARDIOVASCULAR: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply and explain any responses.*

- ☐ Heart attack or coronary. If yes, give date and treatment type. _____
- ☐ Severe pains or feeling of tightness in the chest
- ☐ Abnormal electrocardiogram *(EKG)*
- ☐ Heat exhaustion or heat stroke
- ☐ Chest pains after climbing one flight of stairs
- ☐ Pain going down the left arm/shoulder or into jaw
- ☐ Chest pain when excited or angry
- ☐ Feeling heart is beating too fast or too hard
- ☐ High blood pressure or hypertension
- ☐ Severe leg cramps after walking
- ☐ Severe or painful varicose veins
- ☐ Phlebitis
- ☐ Swollen feet or ankles in the evening
- ☐ Sleep on two or more pillows at night
- ☐ Fingers painful/changing color in cold
- ☐ Shortness of breath after climbing 1 flight of stairs
- ☐ Awakening at night short of breath
- ☐ Shortness of breath when lying down

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HEMATOLOGY: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Low red blood count or anemia
- ☐ High white-blood count
- ☐ Low white blood count
- ☐ Severe bleeding tendencies
- ☐ High blood-iron count

RESPIRATORY: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Any type of lung disease? If yes, type and what treatment? _____
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Severe soaking sweats at night
- ☐ Chronically coughing up abundant sputum
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Emphysema
- ☐ Collapsed lung
- ☐ Sensation of smothering
- ☐ Fear of tight enclosed places
- ☐ Positive tuberculin skin test? If yes, when? _____
- ☐ Tuberculosis
- ☐ Close contact with someone who has/had tuberculosis
- ☐ Hay fever
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Rib injury or fracture

ENDOCRINE: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Diabetes
- ☐ Goiter
- ☐ Gout
- ☐ Low thyroid function
- ☐ Overactive thyroid

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GASTROINTESTINAL: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Cirrhosis or other liver disease
- ☐ Elevated liver function tests
- ☐ Disease of the large intestine or colon
- ☐ Frequent diarrhea
- ☐ Dysentery
- ☐ Gallbladder pain or gallstones
- ☐ Excessive gas or bloating
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Infection with amoeba, parasites, or worms
- ☐ Jaundice *(yellow eyes or skin)*
- ☐ Duodenal or stomach ulcer
- ☐ Frequent/severe nausea, vomiting, or heartburn not relieved by medication
- ☐ Abdominal discomfort after eating fried or fatty foods
- ☐ Vomiting bloody material
- ☐ Severe constipation
- ☐ Frequent use of laxatives or purgatives
- ☐ Thin or pencil-like bowel movements *(stools)*
- ☐ Blood in bowel movements
- ☐ Black tarry bowel movements
- ☐ Colitis *(inflammation of the colon)*
- ☐ Hernia. If yes, Date: _____ Type: _____ Treatment/Surgery: _____

GENITOURINARY: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Recurrent bladder infections
- ☐ Loss of bladder control or leaking
- ☐ Trouble starting or stopping urination
- ☐ Painful urination
- ☐ Persistent bladder pain
- ☐ Commonly getting up at night to urinate
- ☐ Kidney stones
- ☐ Bloody or red color in your urine
- ☐ Nephritis *(inflamed kidney)* or Pyelonephritis *(kidney infection)*

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MUSCULOSKELETAL: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Arthritis
- ☐ Fractures: Date*(s)* and what bone*(s)* _____
- ☐ Painful or swollen joints of the hands and/or feet
- ☐ Knee injury: Date*(s)* and outcome*(s)* _____
- ☐ Frequent or severe low back pain

Have you had a back injury in the past 5 years?	☐ **No** ☐ **Yes**
If yes, was the back injury work related?	☐ **No** ☐ **Yes**
Does back pain make it difficult to keep up with your work?	☐ **No** ☐ **Yes**
Did a Health Care Provider *(MD, DO, DC, NP, or PA)* see/treat you?	☐ **No** ☐ **Yes**

Please explain the kind of treatments received: _____

ELECTRONICALLY POWERED MEDICAL DEVICES (EPMD): Do you currently use or have you been directed and/or instructed by a licensed provider to use any of the following EMPDs?

Internal Medical Device *(i.e., Pacemaker/Implantable Cardioverter-Defibrillator, Insulin Pump, etc.)*	☐ **No** ☐ **Yes**
External Medical Device, including but not limited to the following:	
Blood Glucose Monitor	☐ **No** ☐ **Yes**
Muscle or Nerve Stimulator	☐ **No** ☐ **Yes**
Insulin Pump	☐ **No** ☐ **Yes**
Cardiac Monitor	☐ **No** ☐ **Yes**
Hearing Aid*(es)*	☐ **No** ☐ **Yes**
Implanted hardware *(i.e., knee replacements, metal rods, screws, etc.)*	☐ **No** ☐ **Yes**
Other. Please specify: _____	☐ **No** ☐ **Yes**

SKIN: DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Psoriasis
- ☐ Persistent rashes
- ☐ Persistent itching
- ☐ Frequent skin infections and/or rashes
- ☐ Severe allergic reaction to plants such as poison oak/ivy
- ☐ Hives
- ☐ Eczema
- ☐ Chronic skin problems

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DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD HOBBIES INVOLVING ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Engine exhausts
- ☐ Loud noise *(shooting, motor-cycling)*
- ☐ Paints, solvents or glues
- ☐ Other chemicals. Please list: _____
- ☐ Other exposures. Please list: _____

DO YOU CURRENTLY OR HAVE YOU EVER WORKED WITH OR BEEN EXPOSED TO ANY OF THE FOLLOWING? *Check ALL that apply.*

- ☐ Adhesives
- ☐ Alcohol
- ☐ Arsenic
- ☐ Asbestos
- ☐ Benzene
- ☐ Beryllium
- ☐ Carbon disulfide
- ☐ Carbon tetrachloride *(carbon tet)*
- ☐ Carbon monoxide
- ☐ Chlorine
- ☐ Chloroform
- ☐ Chromate, alodine, chromic acid mist
- ☐ Dimethylformamide *(DMF)*
- ☐ Dust, sandblasting
- ☐ Dust, other
- ☐ Epoxy resins
- ☐ Extreme heat or cold
- ☐ Fiberglass
- ☐ Fluorides
- ☐ Foaming compounds
- ☐ Fumes/vapors
- ☐ High explosives *(HE)*
- ☐ Isocyanates *(TDI, MDI)*
- ☐ Lead
- ☐ Loud or continuous noise
- ☐ Mercury
- ☐ MDA
- ☐ MEK
- ☐ Methylene chloride
- ☐ Mock dust/barium nitrate

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- ☐ Pesticides
- ☐ Phenols
- ☐ Phosgene
- ☐ Plastics
- ☐ Radar microwaves/LASER
- ☐ Exposure to radioactive materials?

If yes, specify isotope*(s)*: _____

- ☐ Silica
- ☐ Solvents/degreasers
- ☐ Spray-painting
- ☐ Trichloroethylene
- ☐ Tritium
- ☐ Vinyl chloride
- ☐ Welding/soldering

Have you ever worn a respirator?	☐ **Yes** ☐ **No**

Describe any conditions/difficulties that might interfere with using a respirator.

PLEASE GIVE APPROXIMATE DATE(s) *(mm/dd/yy)* OF YOUR LAST *(if any)*:

_____ TB test

_____ Hearing test

_____ Eye examination

_____ CAT Scan *(Computerized Axial Tomography)* and what scanned

_____ Radioisotopes and why

_____ Magnetic resonance imaging *(MRI)* and what scanned

_____ Heart catheter

_____ Flu Shot

_____ Hepatitis A shot series

_____ Hepatitis B shot series

_____ Hepatitis AB shot series

HAVE YOU EVER WORKED WITH OR AROUND ANY OF THE FOLLOWING? *Check <u>ALL</u> that apply.*

- ☐ Chemical plant
- ☐ Construction site
- ☐ Electronics plant
- ☐ Farm
- ☐ Fiber mill
- ☐ Foundry
- ☐ Hard-rock mine

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- ☐ Lumber mill
- ☐ Nuclear facility
- ☐ Paper mill
- ☐ Pottery mill
- ☐ Rubber processing plant
- ☐ Refinery
- ☐ Sand pit or quarry
- ☐ Ship yard

List any other types of hazardous facilities at which you have worked:

Explain if you received a medical discharge or disability rating from the military:

If you have ever had cancer, please explain type of tumor, site, and treatment:

Explain if you have a congenital *(born with it)* defect:

Reviewer's Notes:

Signature: _____ **Date:** _____

Reviewer Signature: _____ **Date:** _____

Examiner Signature: _____ ☐ **DO** ☐ **MD** ☐ **NP** ☐ **PA** **Date:** _____