

## ORHC-Occupational Health Services

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ S.S.#: \_\_\_-\_\_\_-\_\_\_ Sex: \_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
 Code: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Employer: \_\_\_\_\_ Position Applied for: \_\_\_\_\_

**Work History (List in order from most recent to first all jobs including military services)**

Date		Position/Job duties	Employer
From	to		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**For questions 1-3 please check all that apply:**

1. Have you ever worked in or around the following:

- Chemical Plant
- Construction Site
- Cotton, Flax or Hemp Mill
- Electronics Plant
- Farm
- Fiber Mill
- Foundry
- Mine
- Outdoor Areas
- Paper/lumber Mill
- Refinery
- Shipyard
- Dusty Jobs
- Other job sites with hazardous exposures: list \_\_\_\_\_

2. Have you ever used or been exposed to the following chemicals or conditions?

- Arsenic
- Asbestos
- Benzene
- Beryllium
- Cadmium
- Carbon Tetrachloride
- Changes in Temperatures
- Chromates
- Dust
- Lead
- Loud Noises
- Mercury/Heavy Metals \_\_\_\_\_
- Lasers
- Pesticides
- Phenols
- Phosgene
- Plastics
- PVC's
- Radioactive materials
- Repetitive Motions
- Solvents/Degreaser
- Spray Painting
- Trichloroethylene
- Others List: \_\_\_\_\_

3. Do you have (or have you ever Had) any hobbies/recreational activities that include:

- Loud Noises (Shooting, motorcycles, etc...)
- Weight Lifting (to \_\_\_ lbs)
- Paints/Solvents/glues
- Other, List: \_\_\_\_\_

4. Have you recently used personal protective equipment for your current or prior job?

- Respirator for \_\_\_\_\_ exposure
- Hearing protection
- Gloves
- Protective Clothing
- Safety Glasses
- Other, List: \_\_\_\_\_

5a. Have you ever received medical surveillance (periodic check-ups or tests) as part of a prior job? ( ) NO ( ) YES, list results \_\_\_\_\_

5b. Have you ever been hurt or injured in previous jobs? ( ) NO ( ) YES, Explain: \_\_\_\_\_

5c. Do you have any environmental allergies? ( ) NO ( ) YES, allergic to: \_\_\_\_\_

5d. Do you have any history of insect or tick bites? ( ) NO ( ) YES, Explain \_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge:

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_