Methodist College
UnityPoint Health

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Health History

Name _____ Date _____

Date of Birth _____ ☐ Male ☐ Female

Please read carefully and answer each item to the best of your knowledge.

DO YOU HAVE OR HAVE YOU EVER HAD (Please check each item yes or no):

	Y	N		Y	N		Y	N		Y	N
Heart disease?			Shortness of breath at night?			Disease of the joints / bones?			Glaucoma or cataract?		
High blood pressure?			Kidney disease?			Swollen painful joints?			Glasses or contact lenses?		
Stroke?			Sugar in your urine?			Arthritis or Gout?			Difficulty hearing?		
Scarlet fever?			Blood in your urine?			Limitation of joint movement?			Dizzy spells or fainting?		
Heart murmur?			Diabetes?			Swelling of ankles or feet?			Frequent or severe headaches?		
Irregular or rapid heart beat?			Liver disease?			Varicose Veins?			Seizure or convulsion?		
Chest Pain?			Jaundice? (other than newborn)			Numbness or tingling in hands or feet?			Hay fever or allergy to plants?		
Abnormal EKG?			Hepatitis?			Broken Bone(s)?			Acne or other skin disease?		
Disease of the lung?			Gall Bladder trouble?			Severe pain in the back or neck?			Tumors, growths, cysts, cancers of the skin?		
Tuberculosis?			Anemia or other blood condition?			Whiplash injury?			Skin rash from soaps, oils, or chemicals?		
Emphysema?			Frequent nausea?			"Trick" shoulder, elbow, or knee?			Reaction to medication?		
Pneumonia?			Stomach or intestinal ulcer?			Back injury?			Used alcohol, drugs, or tobacco?		
Asthma?			Thyroid condition?			Back surgery?			Sexually Transmitted Disease?		
Persistent cough?			Rectal trouble?			Leg cramps while walking?					
Coughed up blood?			Bowel or bladder trouble?			Difficulty with your vision?			Chicken Pox		
Shortness of breath after mild exercise?			Rupture or hernia?			Color Blindness?					

HAVE YOU EVER:

	Yes	No		Yes	No
Taken any medication for your heart?			Worked with particulates, e.g., asbestos, silica, lead?		
Received psychiatric treatment?			Worked around toxic vapors, fumes, or mists?		
Taken medication for anxiety or depression?			Worked around excessive dust?		
Been allergic to any medicines, foods, latex, or powder?			Been exposed to excessive noise?		
Had any serious illness or operations not mentioned above?			Worked with radioactive materials or been treated by radiation?		
Worked with chemicals?			Have you ever had a job related injury or illness?		

PLEASE ANSWER:

	Yes	No
Do you have any restriction codes on your license?		
Are you presently taking any medications?		
Are you presently taking any vitamins and / or herbs?		
Have you been treated by a physician within the last three years?		
Are you pregnant?		
Do you have any physical, mental, or emotional condition, which you believe may affect your attendance or your ability to perform any tasks at work?		

PLEASE EXPLAIN ALL YES ANSWERS:

_____

Signature of Individual Signature of Health Practitioner Date