MISSOURI ARMY NATIONAL GUARD
OCCUPATIONAL HEALTH FORM

Return to:

Occupational Health Nurse
2302 Militia Drive
Jefferson City, MO 65101-1203

IDENTIFICATION DATA

DATE	ORGANIZATION

NAME	GRADE	JOB CODE	SSAN

DATE OF BIRTH (YY/MM/DD)	SEX	RACE	HOME PHONE	DUTY PHONE
		☐ CAU ☐ HISPANIC ☐ BLACK ☐ ORIENTAL ☐ Other _____		

WORKPLACE LOCATION

PURPOSE OF EXAM

☐ BASELINE (Preplacement) ☐ PERIODIC (Special Purpose) ☐ TERMINATION

☐ Other _____

WORK HISTORY (Part 1). List all the jobs you have ever had. Begin with your first job and end with your present job or military assignment. To the right of each job, list the biological, physical, and chemical exposures you received. Use more than one line for each entry and additional blank sheets if necessary.

DATES WORKED		JOB TITLE / WORK ACTIVITIES (Carpenter, Farmer, Cook, etc.)	EXPOSURES		
FROM (month, year)	TO (month, year)		BIOLOGICAL (Viruses, Bacteria, Parasites)	PHYSICAL (Noise, Radiation, Vibrations))	CHEMICAL (Fuels, Solvents, Paints, Pesticides))

WORK HISTORY: (Part II) Answer each of the following questions by marking an "X" in either the "Yes" or "No" box to the right of each question.

	YES	NO
Have you had any work related illness or injury?	☐	☐
Have you had to wear any protective clothing or equipment during your work?	☐	☐
Have you experienced difficulty wearing your protective clothing or equipment?	☐	☐
Have you been limited in your work for health reasons?	☐	☐
Have you received compensation for a work-related illness or injury?	☐	☐
Have you left a job because of health reasons?	☐	☐
Have you had a work-related experience which you believe may have affected your health or the health of fellow workers?	☐	☐

FAMILY HISTORY: Mark an "X" in either the "Yes" or "No" box next to any of the following conditions or diseases anyone in your family (mother, father, brother, sister, grandparent, aunt, uncle, children) has ever had.	YES	NO
ANEMIA, BLOOD DISEASE OR BLEEDING TENDENCY	☐	☐
ASTHMA, HAYFEVER, OR ALLERGIES	☐	☐
BIRTH DEFECT	☐	☐
CANCER OR TUMOR	☐	☐
DIABETES (sugar disease)	☐	☐
EYE TROUBLE	☐	☐
EPILEPSY, FITS OR CONVULSIONS	☐	☐
HEARING TROUBLE, HIGH BLOOD PRESSURE, OR STROKE	☐	☐
KIDNEY TROUBLE	☐	☐
LUNG TROUBLE	☐	☐
SOME OTHER DISEASE OR CONDITION WHICH RUNS IN YOUR FAMILY *(List)*	☐	☐

PERSONAL HISTORY. Answer each of the following questions by making an "X" in either the "Yes" or "No" box to the right of each question.	YES	NO
ARE YOU ALLERGIC OR HAD A BAD REACTION TO ANY DRUG, MEDICATION, CHEMICAL OR OTHER SUBSTANCE (for example: Blood, Bee Sting, Dusts, or Penicillin?)	☐	☐
HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION?	☐	☐
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS, INJURY, OR OPERATION?	☐	☐
HAVE YOU EVER HAD HEPATITIS, LIVER DISEASE, OR YELLOW JAUNDICE?	☐	☐
HAVE YOU EVER HAD ANY SERIOUS ILLNESS, INJURY OR OTHER MEDICAL PROBLEM?	☐	☐
ARE YOU NOW TAKING ANY DRUGS OR MEDICATIONS (Including those you buy without prescription)?	☐	☐
HAVE YOU EVER BEEN TOLD BY A MEDICAL PERSON THAT YOU HAD SOMETHING WRONG WITH YOUR: X-RAY?	☐	☐
BREATHING TEST?	☐	☐
HEARING TEST?	☐	☐
BLOOD TEST?	☐	☐
OTHER_____?	☐	☐
HAVE YOU EVER BEEN ADVISED BY A MEDICAL PERSON TO TAKE MEDICINE FOR: DIABETES?	☐	☐
HIGH BLOOD PRESSURE?	☐	☐
EPILEPSY?	☐	☐
TUBERCULOSIS?	☐	☐
HEART TROUBLE?	☐	☐
DO YOU SMOKE CIGARETTES?	☐	☐
IF YES, HOW MANY PACKS A DAY? _____		
HOW MANY YEARS HAVE YOU SMOKED CIGARETTES? _____		
IF NO, DID YOU EVER SMOKE CIGARETTES?	☐	☐
HOW MANY PACKS A DAY? _____		
HOW MANY YEARS DID YOU SMOKED CIGARETTES? _____ WHAT YEAR DID YOU STOP? _____		
DO YOU SMOKE CIGARS OR A PIPE?	☐	☐
IF YES, HOW MANY CIGARS OR POUCHES PER WEEK? _____		
HOW MANY YEARS HAVE YOU SMOKED CIGARS OR A PIPE? _____		
ID NO, DID YOU EVER SMOKE CIGARS OR A PIPE?	☐	☐
HOW MANY CIGARS OR POUCHES PER WEEK? _____		
HOW MANY YEARS DID YOU SMOKED CIGARS OR A PIPE? _____ WHAT YEAR DID YOU STOP? _____		
HOW MUCH ALCOHOL DO YOU USUALLY DRINK? LIQUOR _____ OUNCES PER WEEK		
BEER _____ BOTTLES PER WEEK		
WINE _____ GLASSES PER WEEK		
HAVE YOU/HAS YOUR SPOUSE EVER TRIED TO HAVE CHILDREN BUT HAVE BEEN UNABLE TO?	☐	☐
HAVE YOU/HAS YOUR SPOUSE EVER BEEN PREGNANT?	☐	☐
IF YES, HOW MANY PREGNANCIES? _____		
DID ANY PREGNANCY RESULT IN AN ABORTION OR MISCARRIAGE? HOW MANY? _____	☐	☐
STILLBIRTH? HOW MANY? _____	☐	☐
PREMATURE BIRTH? HOW MANY? _____	☐	☐
ABNORMAL BIRTH? HOW MANY? _____	☐	☐
IS YOUR SPOUSE/ARE YOU NOW PREGNANT?		

INTERIM HISTORY. Mark an "X" in either the "Yes" or "No" box.
In the past year, have you:

FOR MEN ONLY:

1. NOTICED A DISCHARGE FROM YOUR PENIS?	1. ☐ YES	☐ NO
2. NOTICED ANY LUMPS OR CHANGE IN THE SIZE OF YOUR TESTICLES?	2. ☐ YES	☐ NO
3. HAD PAIN IN YOUR TESTICLES OR PENIS?	3. ☐ YES	☐ NO

FOR WOMEN ONLY:

4. NOTICED A CHANGE IN YOUR MENSTRUAL PERIODS?	4. ☐ YES	☐ NO
5. BEEN TROUBLED WITH MORE PAIN DURING YOUR MENSTRUAL PERIODS THAN USUAL?	5. ☐ YES	☐ NO
6. HAD HEAVIER MENSTRUAL BLEEDING THAN USUAL?	6. ☐ YES	☐ NO
7. HAD ANY VAGINAL BLEEDING BETWEEN YOUR MENSTRUAL PERIODS?	7. ☐ YES	☐ NO
8. BEEN TROUBLED WITH A VAGINAL DISCHARGE?	8. ☐ YES	☐ NO
9. BEEN TROUBLED WITH PAIN DURING SEXUAL INTERCOURSE?	9. ☐ YES	☐ NO

FOR ALL EXAMINEES

10. BEEN TROUBLED WITH DIZZINESS OR LIGHTHEADEDNESS?	10. ☐ YES	☐ NO
11. HAD A FAINTING OR BLACKOUT SPELL?	11. ☐ YES	☐ NO
12. HAD A CONVULSION, FIT, OR SEIZURE?	12. ☐ YES	☐ NO
13. NOTICED WEAKNESS OR PARALYSIS OF ANY PART OF YOUR BODY?	13. ☐ YES	☐ NO
14. HAD TROUBLE KEEPING YOUR BALANCE?	14. ☐ YES	☐ NO
15. NOTICED SHAKING OF ANY PART OF YOUR BODY?	15. ☐ YES	☐ NO
16. NOTICED TINGLING OR NUMBNESS OF ANY PART OF YOUR BODY?	16. ☐ YES	☐ NO
17. NOTICED A DECREASE IN YOUR COORDINATION?	17. ☐ YES	☐ NO
18. HAD A LOSS OF CONSCIOUSNESS?	18. ☐ YES	☐ NO
19. HAD SLURRED SPEECH OR LOSS OF SPEECH?	19. ☐ YES	☐ NO
20. HAD MORE TROUBLE CONCENTRATING ON YOUR WORK THAN USUAL?	20. ☐ YES	☐ NO
21. BEEN MORE WORRIED OR ANXIOUS THAN USUAL?	21. ☐ YES	☐ NO
22. BEEN MORE DEPRESSED OR UNHAPPY THAN USUAL?	22. ☐ YES	☐ NO
23. NOTICED ANY CHANGE IN YOUR PERSONALITY?	23. ☐ YES	☐ NO
24. HAD TROUBLE MAKING DECISIONS?	24. ☐ YES	☐ NO
25. BEEN TROUBLED WITH PERIODS OF MENTAL CONFUSION OR DISORIENTATION?	25. ☐ YES	☐ NO
26. HAD ANY SEXUAL DIFFICULTIES?	26. ☐ YES	☐ NO
27. BEEN TROUBLED WITH PAIN IN YOUR JOINTS?	27. ☐ YES	☐ NO
28 NOTICED STIFFNESS OF ANY OF YOUR JOINTS?	28. ☐ YES	☐ NO
29. NOTICED SWELLING OR REDNESS OF ANY OF YOUR JOINTS?	29. ☐ YES	☐ NO
30. BEEN TROUBLED WITH BACK PAIN?	30. ☐ YES	☐ NO
31. HAD DIFFICULTY WALKING?	31. ☐ YES	☐ NO
32. NOTICED A CHANGE IN THE COLOR OF YOUR SKIN?	32. ☐ YES	☐ NO
33. BEEN TROUBLED WITH ITCHING SKIN, ACNE, OR SKIN RASHES?	33. ☐ YES	☐ NO
34. DEVELOPED ANY GROWTHS OR SORES ON YOUR SKIN?	34. ☐ YES	☐ NO
35. NOTICED A CHANGE IN ANY GROWTH OR SORES?	35. ☐ YES	☐ NO
36. NOTICED A CHANGE IN OR HAD BLEEDING OF A MOLE?	36. ☐ YES	☐ NO
37. NOTICED YOU BRUISE MORE EASILY OR HAVE TROUBLE STOPPING EVEN A SMALL CUT FROM BLEEDING?	37. ☐ YES	☐ NO
38. HAD EYE IRRITATION OR PAIN?	38. ☐ YES	☐ NO
39. NOTICED A DECREASE IN YOUR ABILITY TO SEE?	39. ☐ YES	☐ NO
40. HAD DOUBLE VISION OR SLURRED VISION?	40. ☐ YES	☐ NO
41. HAD UNEXPLAINED FLASHES OF LIGHT, HALOS OR FLOATING OBJECTS IN FRONT OF YOUR EYES?	41. ☐ YES	☐ NO
42. HAD A TEMPORARY LOSS OF VISION?	42. ☐ YES	☐ NO

INTERIM HISTORY (Continued)

In the past year, have you:

43. HAD MORE THAN THREE COLDS? 43. ☐ YES ☐ NO
44. HAD WHEEZING? 44. ☐ YES ☐ NO
45. BEEN TROUBLED WITH COUGHING? 45. ☐ YES ☐ NO
46. COUGHED UP THICK MUCOUS OR PHLEGM (THICK SPIT) 46. ☐ YES ☐ NO
47. COUGHED UP BLOOD? 47. ☐ YES ☐ NO

48. HAD TIGHTNESS, PRESSURE, OR PAIN IN YOUR CHEST 48. ☐ YES ☐ NO
49. HAD RACING OR THUMPING OF YOUR HEART? 49. ☐ YES ☐ NO
50. SHORTNESS OF BREATH? 50. ☐ YES ☐ NO
51. HAD TROUBLE BREATHING WHEN YOU EXERT YOURSELF? 51. ☐ YES ☐ NO
52. HAD TROUBLE BREATHING WHEN YOU LIE DOWN? 52. ☐ YES ☐ NO
53. NEEDED TO USE MORE THAN ONE PILLOW OR RAISE THE HEAD OF YOUR BED TO GO TO SLEEP? 53. ☐ YES ☐ NO
54. AWAKENED AND HAD TROUBLE CATCHING YOUR BREATH? 54. ☐ YES ☐ NO
55. NOTICED SWELLING IN YOUR FEET OR ANKLES? 55. ☐ YES ☐ NO
56. HAD PAIN OR CRAMPS IN YOUR LEGS WHEN YOU WALK? 56. ☐ YES ☐ NO
57. NOTICED YOUR HANDS, FEET OR LIPS TURN BLUE OR BLEACH WHITE? 57. ☐ YES ☐ NO

58. HAD DIFFICULTY SWALLOWING? 68. ☐ YES ☐ NO
59. BEEN TROUBLED WITH BELCHING, BLOATING, OR HEARTBURN? 59. ☐ YES ☐ NO
60. BEEN TROUBLED WITH STOMACH OR ABDOMINAL PAIN? 60. ☐ YES ☐ NO
61. BEEN TROUBLED WITH NAUSEA, VOMITING, OR BELCHING UP FOOD? 61. ☐ YES ☐ NO
62. VOMITED BLOOD? 62. ☐ YES ☐ NO
63. BEEN TROUBLED WITH DIARRHEA OR LOOSE STOOLS? 63. ☐ YES ☐ NO
64. BEEN TROUBLED WITH CONSTIPATION? 64. ☐ YES ☐ NO
65. NOTICED A CHANGE IN YOUR BOWEL HABITS? 65. ☐ YES ☐ NO
66. NOTICED A CHANGE IN THE COLOR OR CONSISTENCY OF YOUR STOOL? 66. ☐ YES ☐ NO
67. HAD ANY BLOODY OR BLACK, TARRY LOOKING STOOLS? 67. ☐ YES ☐ NO
68. BEEN TROUBLED WITH RECTAL OR ANAL PAIN? 68. ☐ YES ☐ NO
69. NOTICED ANY RECTAL OR ANAL BLEEDING? 69. ☐ YES ☐ NO

70. HAD ANY BURNING OR PAIN WHEN YOU URINATE? 70. ☐ YES ☐ NO
71. NOTICED ANY BLOOD IN YOUR URINE? 71. ☐ YES ☐ NO
72. NOTICED A CHANGE IN THE COLOR OF YOUR URINE? 72. ☐ YES ☐ NO
73. HAD TO URINATE MORE OFTEN THAN USUAL? 73. ☐ YES ☐ NO
74. HAD TO WAKE UP AT NIGHT TO URINATE? 74. ☐ YES ☐ NO
75. HAD DIFFICULTY CONTROLLING YOUR URINE? 75. ☐ YES ☐ NO
76. HAD DIFFICULTY IN STARTING YOUR URINE FLOW? 76. ☐ YES ☐ NO

INTERIM HISTORY (CONTINUED)

IN THE PAST YEAR, HAVE YOU:

77. HAD A WEIGHT CHANGE OF MORE THAN 10 POUNDS? 77. ☐ YES ☐ NO
78. MADE A CHANGE IN APPETITE 78. ☐ YES ☐ NO
79. BEEN MORE THIRSTY THAN USUAL? 79. ☐ YES ☐ NO
80. HAD MORE FATIGUE THAN USUAL? 80. ☐ YES ☐ NO
81. HAD MORE WEAKNESS THAN USUAL? 81. ☐ YES ☐ NO
82. HAD FEVER OR CHILLS? 82. ☐ YES ☐ NO
83. HAD TROUBLE TOLERATING HEAT OR COLD? 83. ☐ YES ☐ NO
84. HAD NIGHT SWEATS? 84. ☐ YES ☐ NO
85. HAD MORE TROUBLE SLEEPING THAN USUAL? 85. ☐ YES ☐ NO
86. NOTICED A DISCHARGE FROM EITHER BREAST? 86. ☐ YES ☐ NO
87. NOTICED A LUMP IN EITHER BREAST? 87. ☐ YES ☐ NO
88. BEEN TROUBLED WITH PAIN IN YOUR BREASTS? 88. ☐ YES ☐ NO
89. NOTICED A GROWTH OR LUMP ON ANY PART OF YOUR BODY? 89. ☐ YES ☐ NO
90. HAD ANY PROBLEM WITH YOUR HAIR OR NAILS? 90. ☐ YES ☐ NO
91. BEEN TROUBLED WITH PAIN IN YOUR ARMS, LEGS, FEET OR HANDS? 91. ☐ YES ☐ NO
92. NOTICED A DECREASE IN YOUR ABILITY TO PERFORM CERTAIN PHYSICAL ACTIVITIES? 92. ☐ YES ☐ NO

93. HAD PAIN OR STIFFNESS OF YOUR NECK? 93. ☐ YES ☐ NO
94. NOTICED ANY LUMPS OR SWELLING IN YOUR NECK? 94. ☐ YES ☐ NO
95. BEEN TROUBLED WITH HEADACHES? 95. ☐ YES ☐ NO

96. NOTICED A DECREASE IN YOUR ABILITY TO SMELL? 96. ☐ YES ☐ NO
97. BEEN TROUBLED WITH A DISCHARGE FROM YOUR NOSE? 97. ☐ YES ☐ NO
98. HAD NOSEBLEEDS? 98. ☐ YES ☐ NO
99. NOTICED SORES IN YOUR NOSE? 99. ☐ YES ☐ NO
100. HAD TROUBLE BREATHING THROUGH YOUR NOSE? 100. ☐ YES ☐ NO
101. BEEN TROUBLED WITH IRRITATION OF YOUR NOSE? 101. ☐ YES ☐ NO
102. HAD NOSE HOARSENESS OR TROUBLE TALKING? 102. ☐ YES ☐ NO

103. NOTICED BLEEDING OR IRRITATION OF YOUR GUMS OR TONGUE? 103. ☐ YES ☐ NO
104. NOTICED ANY SORES IN YOUR MOUTH? 104. ☐ YES ☐ NO
103. NOTICED A CHANGES IN THE TASTE OF FOOD OR DRINK? 105. ☐ YES ☐ NO
106. NOTICED A DECREASE IN YOUR ABILITY TO HEAR? 106. ☐ YES ☐ NO
107. HAD RINGING OR OTHER UNUSUAL SOUNDS IN YOUR EARS? 107. ☐ YES ☐ NO
108. HAD PAIN IN YOUR EARS? 108. ☐ YES ☐ NO

109. DO YOU NAVE ANY CONCERNS YOU WISH TO DISCUSS WITH THE PHYSICIAN? 109. ☐ YES ☐ NO

Occupational Health Form

Please explain all yes answers from questionnaire in this space. Include onset of signs or symptoms. List any other medical concerns not previously addressed.

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER *(SSN)*

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/ beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE