azb
arbeitsmedizinisches zentrum basel

Medical Questionnaire – Occupational Health

Name, First Name: ..... **Date of Birth:** .....

Employer: ..... **Occupation:** .....

Former Occupations:

Period	Employer	Occupation

Occupational Exposures to:

Please mark all categories to which you had been (potentially) exposed to during a period of over 6 months:

solvents	☐ no	☐ yes - which ones?
substances CMR	☐ no	☐ yes - which ones?
heavy metals	☐ no	☐ yes - which ones?
dust	☐ no	☐ yes - what kind of?
noise	☐ no	☐ yes - what kind of?
ionising radiation	☐ no	☐ yes - what kind of?
infectious agents	☐ no	☐ yes - which ones?
animals	☐ no	☐ yes - which ones?

Have you ever had a period of incapacity for work of > 1 month or did you ever need to change your occupation because of an illness or an accident? ☐ no ☐ yes

If so: when? ..... for how long? ..... reason: .....

Have you been declared unfit for military service? ☐ no ☐ yes

if so, for what reason? .....

Medical History of the Family

Please mention if someone of your close family (grand-parents, parents, uncles and aunts, brothers and sisters) has been or is suffering of one of the following medical conditions:

arterial hypertension	☐ no	☐ yes - who?
diabetes	☐ no	☐ yes - who?
myocardial infarction	☐ no	☐ yes - who?
Stroke	☐ no	☐ yes - who?
tumour	☐ no	☐ yes - who? what kind of?
epilepsy	☐ no	☐ yes - who?
allergies	☐ no	☐ yes - who? against what?

Actual Health

Do you actually suffer from a medical condition? ☐ no ☐ yes

if so, what of?

.....

Are you actually taken care of by a physician and/or a psychotherapist, a physiotherapist? ☐ no ☐ yes

If so, for what reason(s) (diagnosis)?

.....

Is you working ability limited for the time being? ☐ no ☐ yes

Do you wear glasses/contact lenses? ☐ no ☐ yes

Ladies: Are you pregnant? ☐ no ☐ yes

Do you do sports? ☐ no ☐ yes: what kind of? .....

please turn over

Do you smoke? ☐ no ☐ yes if so, since when? …….. what ? ……..
☐ no - stopped how many years ago …….. what ? ……..

Alcoholic beverage? ☐ no ☐ yes if so, what kind of, how much & frequency
……

Do you consume drugs? ☐ no ☐ yes if so, what kind of, how much & frequency ……..

Please mention ALL medication that you take actually - including "the pill" :

……

Height and Weight? .....cm ..... kg

Past Medical History

Please mention **all medical conditions** of which you have been suffering from and also**, when**
... **severe medical conditions** (e.g. cardio-vascular-diseases, stroke, cancer, etc.),
... **surgery** (e.g. tonsils, appendicitis, inguinal hernia, intervertebral disc, eyes, etc.), or
... **accidents, injuries** (e.g. fractures, torn ligaments, etc.).

……

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……

Past Medical History (organ systems)

Have you ever suffered from /Do you suffer from:
if so, please mark it by underlining the condition

epilepsy, giddiness, loss of consciousness, memory disorder, chronic headache, migraine, palsy, balance disorder etc.	☐ no ☐ yes
heart insufficiency, acute cardiac infarction, angina pectoris, disorders of heart beat, high / low blood pressure, collapse, disorders of (peripheral) arteries / veins etc.	☐ no ☐ yes
bronchial asthma, chronic bronchitis, pneumonia / pleurisy, lung tuberculosis etc.	☐ no ☐ yes
gastric disorder (e.g. ulcers, inflammations, reflux), intestinal disease (e.g. inflammations [Crohn's disease], diverticulitis, anal fistula, haemorrhoids; polyps), gall stone, liver disease, pancreatitis etc.	☐ no ☐ yes
metabolic disorders (e.g. diabetes, high cholesterol, gout, thyroid gland disorders, intolerance to lactose or to gluten etc.)	☐ no ☐ yes
psychiatric disorders, vertigo, claustrophobia, depression, suicide attempt, drug dependence, withdrawal therapy [alcohol, illicit substance, medical drugs)	☐ no ☐ yes
sleep disorders, snoring, respiratory pauses during sleep, increased fatigue during daytime	☐ no ☐ yes
hearing problems (e.g. sudden hearing loss, ear buzzing, hardness of hearing etc.) eye problems (e.g. glaucoma, cataract, retinal detachment etc.)	☐ no ☐ yes
blood disorders (e.g. anaemia etc.), disorders of blood clotting, swollen lymph nodes,	☐ no ☐ yes
disorders of the vertebral column (e.g. lumbago, disc hernia, scoliosis etc.)	☐ no ☐ yes
bone disease - joint disorders (e.g. arthrosis, rheumatism etc.) - muscle disorder	☐ no ☐ yes
kidney disorders (e.g. cysts, infections, inflammations, stones, malformations etc.)	☐ no ☐ yes
allergies (e.g. pollen, pet animals, lab animals, insect bites, medical drugs etc.) - skin disorders (e.g. eczema, psoriasis, tumour etc.)	☐ no ☐ yes
infectious intestinal disease (e.g. salmonellosis, shigellosis, amoebic, lambliasis, worms) - urinary tract infection OR sexually transmitted disease	☐ no ☐ yes

With signing the form I confirm having filled it out with care and that I did neither suppress nor give false information.
Also – with signing the form I discharge my family doctor and/or the treating specialist from professional confidentiality vis-à-vis the azb physicians, allowing exchange of medical information to safely handle an (occupational) health issue.

Place and Date: Signature: