DEVELOPMENT OF MEDICAL AND OCCUPATIONAL HISTORY FORMS FOR THE NAVY OCCUPATIONAL HEALTH INFORMATION MANAGEMENT SYSTEM

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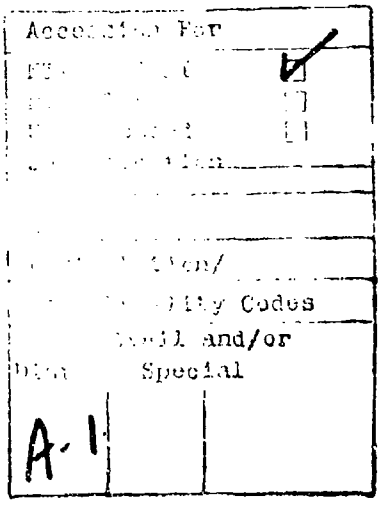
SUMMARY

The development of the Medical and Occupational History Forms in support of the Navy's occupational, safety and health programs reflect a concerted effort to establish a comprehensive summary of an individual's medical, employment, and exposure history throughout his or her adult life and help establish a valuable baseline. The Medical History Form consists of four sections: family history, past medical history, personal history, and review of systems. The Occupational History Form consists of three sections: occupational exposure inventory, environmental history, and chronological occupational exposure. The ascertainment of past medical and occupational histories requires a full understanding of a worker's current health status and the potential impact on health and future job performance. Cogent and timely use of such information contributes to more informed medical and administrative decision-making in terms of job placement and health risk.



Development of Medical and Occupational History Forms for the Navy Occupational Health Information Management System

INTRODUCTION

Occupational health programs are multidisciplinary in nature, involving primarily the fields of occupational medicine, epidemiology, industrial hygiene and toxicology. The computerized occupational health information system, to be maximally effective, should incorporate, as a minimum, the following types of information: (a) detailed worker and job histories and demographic data; (b) an inventory of possible exposures and their potential adverse health effects related to specific workplace location; (c) worksite exposure data, and (d) employee medical information collected throughout the worker's career.

The objective of the Navy Occupational Health Information Management System (NOHIMS) is to provide an information system that will coordinate the components of the Navy's occupational health program in order to satisfy the requirements of the Occupational Safety and Health Act of 1970 (1) by helping to provide a safe and healthful working environment for all employees in Navy industrial facilities.

In order to provide the information needed to coordinate the components of the Navy's occupational health programs, NOHIMS utilizes a database consisting of three basic types of data entered into the system on a continual basis. These data comprise the personnel, environmental and medical files and are discussed in detail elsewhere (2-4).

A presentation of the types of information contained in the NOHIMS database is shown in Figure 1. In this figure, personnel (occupational histories) and environmental (industrial activities, workplace environments and hazard profiles) data, for the worker population, are subsumed under the more general label of occupational health data. This report describes the initial development of the encounter forms that are designed to collect individual medical and occupational data elements and establish a baseline information base.

DESIGN AND DEVELOPMENT

Department of Defense (5) and Department of the Navy (6-8) instructions have directed the establishment of comprehensive, aggressive and effective occupational safety and health programs in support of the Occupational Safety and Health Act (1). Among other tasks, these instructions require "...periodic surveillance to confirm or detect early presymptomatic exposure to health hazards, materials and environments at the worksite." Compliance with these instructions has engendered the need to develop a comprehensive record system that can monitor and document employee health and exposure patterns for extended periods of time.

The ascertainment of an individual's previous medical, occupational health care and job experience histories requires a full understanding of a worker's current health status and the potential impact on health risk and future job performance. Cogent and timely use of such information would contribute to more informed medical and administrative decision-making in terms of job placement and health risk.

Various corporate and medical surveillance information systems (9) and other sources (10-11) provided guidance for the basic structural design and identification of key data elements nec-

essary to provide detailed medical and occupational histories. An essential requirement of these data elements is that they be coded and formatted in a manner that is compatible with other medically related NOHIMS modules. The Computer STored Ambulatory Record (COSTAR) medical information system satisfies this criterion. COSTAR provides extensive user help, aids, and explanation techniques and is written in the American National Standards Institute (ANSI) standard MUMPS language (2) recently approved for use by DOD (12).

Appendices A and B represent the initial conceptual development of the medical and occupational history forms, respectively. These forms reflect a concerted effort to provide a comprehensive medical and occupational history based on information of importance to both the occupational physician and epidemiologist.

DESCRIPTION

Medical History Form - The Medical History Form (MEDHX) consists of 13 pages and is divided into four sections: family history (FH), past medical history (PMH), personal history (PH), and review of systems (ROS). The family history section requests information about various diseases or conditions that a worker's family members have or may have had in the past. The past medical history section asks the worker to answer questions concerning allergies, immunizations, use of medicines, hospitalizations and operations, injuries, and treatments for other than minor conditions over the past five years. Some basic demographic information including marital and veteran status is ascertained in the personal history section. In addition, information about lifestyle habits such as smoking, alcohol consumption and exercise is requested in this section. The final section of the medical history form provides a comprehensive review of body and organ systems. All of the items covered in the Report of Medical History (SF-93) have been integrated into this section in addition to other pertinent medical information. Systems reviewed include the skin, eyes, ears and hearing, nose-throat-mouth-teeth, respiratory and cardiovascular systems, gastrointestinal, urinary and reproductive systems, musculoskeletal and nervous systems, and a miscellaneous category to cover diseases or conditions that do not fall under any of the other systems.

Occupational History Form - The basic format of the Occupational History Form (OCCHX) consists of 6 pages and is divided into three primary sections: occupational exposure inventory (OEI), environmental history (ENV), and chronological occupational profile (COP). The occupational exposure inventory section requests information concerning previous work-related injuries or health problems that may have led to lost work time, or refusal of employment or compensation. The environmental history section gathers information about various non-work related hazardous exposures encountered by the respondent (e.g., type of home heating and cooking devices, hobbies, and domestic chemical exposures). These two sections will be completed once during the pre-employment medical examination with changes submitted on an annual basis, or as required. The final section, chronological occupational profile, asks the respondent about his or her employment status (current or most recent job), health problems or injuries, hazardous exposures and use of personal protective equipment related to this job. The COP will be completed for all jobs (including military service) that an individual has held since high school or age eighteen.

IMPLEMENTATION

The current implementation plans are to conduct initial testing of the Medical and Occupational History forms at the Civil Service Dispensary located at the North Island Naval Air Station, San Diego, California. The forms will be completed by prospective employees of the Naval Air Rework Facility during the preliminary phases of their pre-employment medical examination. Although the prototype NOHIMS application is directed towards civilian employees, use of these forms can be easily adapted to other industrial activities at North Island employing both civilian and military personnel. Upon final acceptance and dissemination of NOHIMS, all civilian employees and military personnel who have not previously filled out these forms will be required to do so on a one-time basis. A periodic (usually annual) update of a worker's medical, home environment and occupational status will be conducted to determine if there have been any changes in health risk. Information from the completed forms will be reviewed by an occupational physician and/or nurse and entered into NOHIMS by data entry clerks.

DISCUSSION

The use of the Medical and Occupational History forms will provide a comprehensive summary of an individual's medical, employment and exposure history throughout his or her adult life and help establish a valuable baseline. For example, if a person starts working at a Naval activity with a physical or medical impairment incurred prior to this employment, the government needs to document that fact. Such workers would be identified via the Medical and Occupational History Forms. This type of information would be valuable in determining appropriate job placement and/or medical care, if warranted.

One must keep in mind that with the exception of verifiable demographic data (social security number, age, veteran status), most of the other information is based on an individual's memory and, therefore, may be subject to recall bias. The standardization and structure of the forms and clear and concise wording of the questions will lessen the likelihood of this type of bias.

The storage of information in computers greatly increases the ease of information retrieval and, consequently, the potential for epidemiological studies. Preservation of this potential may be realized by maximizing input from the employee during the initial encounter.

The length of the forms and the time required to complete them may raise concerns from both management and medical personnel especially in terms of lost production time and increased medical review and data entry time. An additional concern may be the limits of worker attention span and endurance in completing the forms. This point is especially relevant depending on the number of primary jobs that an individual has had during his or her years of employment.

These forms represent the initial effort to consolidate all pertinent medical, occupational and exposure information into a comprehensive data file. Following field testing, design changes and additions or deletions of data elements may be expected. The ensuing modifications of these initial forms, then, will represent an effort to strike a reasonable balance between the scientific goals and practical considerations described.

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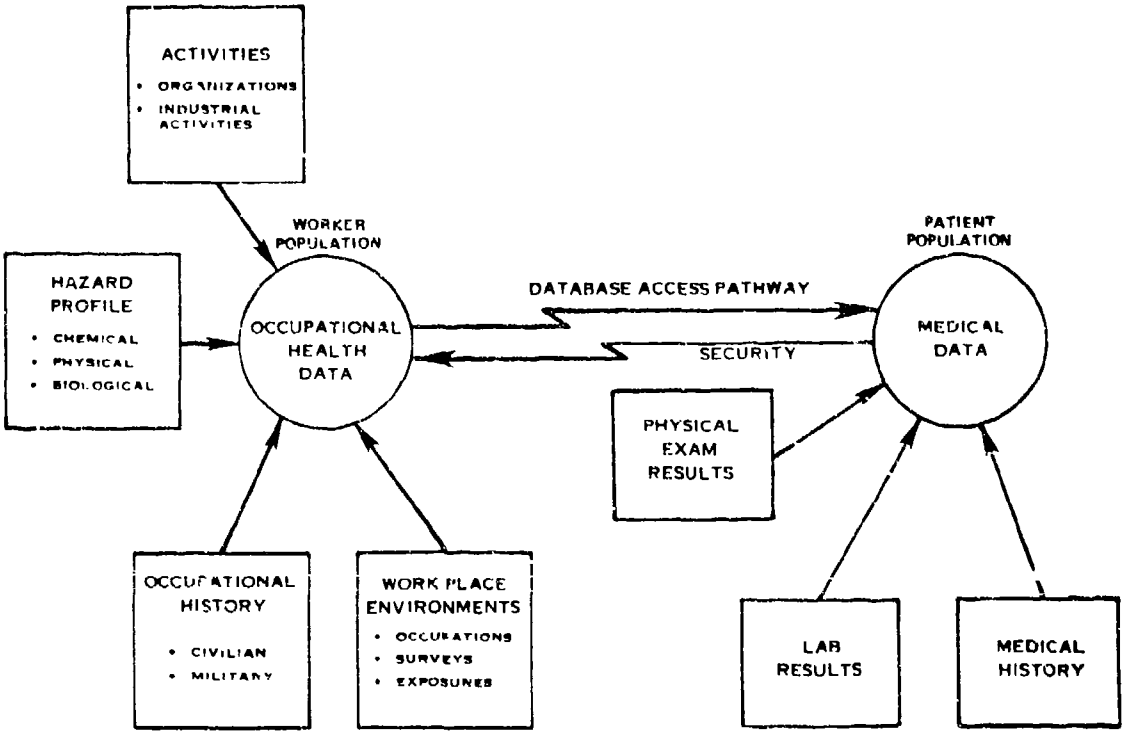

TYPES OF INFORMATION CONTAINED IN THE NOHIMS DATABASE

Figure 1

OCCUPATIONAL HEALTH CARE
MEDICAL HISTORY

MEDHX
FH/PMH

Please answer the following questions about your medical history as best you can. Afterwards, the nurse or doctor will go over your answers with you in private.

NOTE All of this information remains part of your confidential medical record. It can be released only by your signed permission. The information will be used to help provide better medical services to you.

SOCIAL SECURITY NUMBER	TODAY'S DATE	*OFFICE USE ONLY* PROVIDER NO. 1	PROVIDER NO. 2
___-___-____	___/___/___ MONTH DAY YEAR	LAST NAME	LAST NAME

FAMILY HISTORY (FH)

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING CONDITIONS OR DISEASES? ("Family" includes Mother, Father, Brother, Sister, Grandparent, Aunt, Uncle, or Children.)

Check only one box for each question.

		(Y)ES	NOT (S)URE	NO
(ADB-)	Anemia, blood disease, or bleeding tendency?	☐	☐	☐
(AHL-)	Asthma, hayfever, or allergies?	☐	☐	☐
(BDF-)	Birth defect(s)?	☐	☐	☐
(CTM-)	Cancer or tumor(s)?	☐	☐	☐
(DBT-)	Diabetes (sugar disease)?	☐	☐	☐
(EPI-)	[illegible] convulsions?	☐	☐	☐
(HTP-)	Heart trouble (including angina), high blood pressure, or stroke?	☐	☐	☐
(OFD-)	Some other disease(s) or condition(s) not given above which runs in your family? *If you checked YES or NOT SURE*, please specify the disease(s) or condition(s).	☐	☐	☐

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

FOR OFFICE USE ONLY
(FNG) ☐
All neg ans

PAST MEDICAL HISTORY (PMH)

ALLERGIES

Check only one box.

		(Y)ES	NOT (S)URE	(N)O
(PRX-)	Have you ever had any allergic or adverse reaction (hives, skin rash, itching, swollen eyes, trouble with breathing, etc.) from any medicine, drug, food substance, or material of any kind?	☐	☐	☐

If YES or NOT SURE, list the year(s) [as best you can] and the substance(s) [if known] that caused the allergic or adverse reaction(s).

(AY1) Year *(Write in)* 19 ___		(AY2) Year *(Write in)* 19 ___	
(AS1) Substance *(Write in)* ___ ___ ___ ___ ___ ___ ___		(AS2) Substance *(Write in)* ___ ___ ___ ___ ___ ___ ___	
(AY3) Year *(Write in)* 19 ___		(AY4) Year *(Write in)* 19 ___	
(AS3) Substance *(Write in)* ___ ___ ___ ___ ___ ___ ___		(AS4) Substance *(Write in)* ___ ___ ___ ___ ___ ___ ___	
(AY5) Year *(Write in)* 19 ___		(AY6) Year *(Write in)* 19 ___	
(AS5) Substance *(Write in)* ___ ___ ___ ___ ___ ___ ___		(AS6) Substance *(Write in)* ___ ___ ___ ___ ___ ___ ___	

NHRC (11-13-84)

PAST MEDICAL HISTORY (PMH) (CONT.)

IMMUNIZATIONS

HAVE YOU HAD A: *Check only one box for each question.*

		(Y)ES	NOT (S)URE	(N)O
(TMM-)	Tetanus immunization in the last 10 years?	☐	☐	☐
(DMM-)	Diphtheria immunization?	☐	☐	☐
(PMM-)	Polio immunization?	☐	☐	☐

MEDICINES

ARE YOU TAKING ANY OF THESE MEDICINES REGULARLY (at least once per week)? (SF 93/8)

	(Y)ES	NO	
(APR-)	☐	☐	Aspirin (includes Ascripton, Bufferin, Anacin, or other medicines containing aspirin) *Specify:*
(ATB-)	☐	☐	Antibiotics (drugs to control infections such as penicillin) *Specify:*
(AAM-)	☐	☐	Allergy/asthma medicine (during last 12 months) *Specify:*
(BPM-)	☐	☐	Blood pressure medicine *Specify:*
(BT-)	☐	☐	Blood thinner (anticoagulant) *Specify:*
(DRT-)	☐	☐	Diuretics (water pills) *Specify:*
(IFD-)	☐	☐	Insulin for diabetes *Specify:*
(PCD-)	☐	☐	Pills or capsules for diabetes *Specify:*
(LXT-)	☐	☐	Laxatives *Specify:*
(MSZ-)	☐	☐	Medicine for seizures or convulsions (epilepsy) *Specify:*
(NDH-)	☐	☐	Nitroglycerin, Digoxin, or other heart medicine *Specify:*
(SMD-)	☐	☐	Stomach medicine (e.g., Tums, Rolaids, Gelucil) *Specify:*
(TMD-)	☐	☐	Thyroid medicine *Specify:*
(TQS-)	☐	☐	Tranquilizers or sleeping pills (e.g., Librium, Valium, Thorazine) *Specify:*
(MDV-)	☐	☐	Vitamins (high dosage only) *Specify:*
(BCP-)	☐	☐	Birth control pills *Specify:*
(STP-)	☐	☐	Steroid (e.g., Cortisone) pills or capsules *Specify:*

(MTR) List the names of any other medicines that you take regularly (at least once per week). (SF 93/8)

_____ _____ _____

_____ _____ _____

_____ _____ _____

FOR OFFICE USE ONLY

(MDNG) ☐
All neg ans

Check only one box.

		(Y*)ES	NOT (S*)URE	(N)O
(SDM-)	Have you ever had an adverse or allergic reaction to any serum, drug, or medicine? (SF 93/11-29)	☐	☐	☐

If YES or NOT SURE, please describe the reaction. _____

_____

PAST MEDICAL HISTORY (PMH) (CONT.)

HOSPITALIZATIONS AND OPERATIONS

LIST ALL HOSPITAL ADMISSIONS AND OPERATIONS FOR ANY REASON. (SF 93/18&19)

IF NONE, CHECK HERE: ☐ (NHS) No hospitalization(s) and/or operation(s)

If any, please describe the hospitalization(s) and/or operation(s) below.

BOX 1 (HP1) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________	BOX 2 (HP2) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________
BOX 3 (HP3) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________	BOX 4 (HP4) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________
BOX 5 (HP5) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________	BOX 6 (HP6) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________
BOX 7 (HP7) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________	BOX 8 (HP8) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________
BOX 9 (HP9) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________	BOX 10 (HP10) Year(*Write in*) 1 9 __ __ Reason(*Write in*)__________ Name of Hospital, City, and State(*Write in*) ________________ ________________

Check only one box.

	(Y*)ES	NOT (S*)URE	(N)O
(ADV-) Were you ever advised to have an operation that you did not have? (SF 93/18)	☐	☐	☐

If YES or NOT SURE, describe. ________________________________
____

PAST MEDICAL HISTORY (PMH) (CONT.)

INJURIES

Check only one box.

		(Y)ES	NOT (S)URE	(N)O
(SIJ-)	Have you ever had any serious injuries? (SF 93/20)	☐	☐	☐

If YES or NOT SURE, please describe the injury(ies) below.

(SJ1) Year(Write in) 1 9 _ _ Injury(Describe) _ _ _ _ _ _ _ _ _ _

(SJ2) Year(Write in) 1 9 _ _ Injury(Describe) _ _ _ _ _ _ _ _ _ _

(SJ3) Year(Write in) 1 9 _ _ Injury(Describe) _ _ _ _ _ _ _ _ _ _

(SJ4) Year(Write in) 1 9 _ _ Injury(Describe) _ _ _ _ _ _ _ _ _ _

(SJ5) Year(Write in) 1 9 _ _ Injury(Describe) _ _ _ _ _ _ _ _ _ _

(SJ6) Year(Write in) 1 9 _ _ Injury(Describe) _ _ _ _ _ _ _ _ _ _

TREATMENTS

Check only one box.

		(Y)ES	NOT (S)URE	(N)O
(CTC-)	Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (SF 93/21)	☐	☐	☐

If you have consulted or been treated or are NOT SURE, please describe the treatment(s) below.

(CT1) Year(Write in) 1 9 _ _
Name and Address of Doctor, Clinic, etc. _ _ _ _ _ _ _ _ _ _
Treatment(Describe) _ _ _ _ _ _ _ _ _ _

(CT2) Year(Write in) 1 9 _ _
Name and Address of Doctor, Clinic, etc. _ _ _ _ _ _ _ _ _ _
Treatment(Describe) _ _ _ _ _ _ _ _ _ _

(CT3) Year(Write in) 1 9 _ _
Name and Address of Doctor, Clinic, etc. _ _ _ _ _ _ _ _ _ _
Treatment(Describe) _ _ _ _ _ _ _ _ _ _

(CT4) Year(Write in) 1 9 _ _
Name and Address of Doctor, Clinic, etc. _ _ _ _ _ _ _ _ _ _
Treatment(Describe) _ _ _ _ _ _ _ _ _ _

		(E)XCELLENT	(G)OOD	(F)AIR	(P)OOR	(D)ON'T KNOW
(HHH-)	How is your health now? (SF 93/8) Check only one box.	☐	☐	☐	☐	☐

		(Y)ES	NOT (S)URE	(N)O
(HDD-)	Do you have a doctor (or doctors)? Check only one box.	☐	☐	☐

If you have a doctor or doctors, please identify below.

(DN1) Name _ _ _ _ _ _ _ _ _ _
Address _ _ _ _ _ _ _ _ _ _
_ _ _ _ _ _ _ _ _ _

(DN2) Name _ _ _ _ _ _ _ _ _ _
Address _ _ _ _ _ _ _ _ _ _
_ _ _ _ _ _ _ _ _ _

(DN3) Name _ _ _ _ _ _ _ _ _ _
Address _ _ _ _ _ _ _ _ _ _
_ _ _ _ _ _ _ _ _ _

(DN4) Name _ _ _ _ _ _ _ _ _ _
Address _ _ _ _ _ _ _ _ _ _
_ _ _ _ _ _ _ _ _ _

		(Y)ES	(D)ON'T KNOW	(N)O
(WLR-)	If you do not have a doctor, would you like us to refer you to a doctor? Check only one box.	☐	☐	☐

PERSONAL HISTORY (PH)

Check one box for each question unless otherwise indicated.

(LVE-) Have you lived in or visited other parts of the USA or foreign countries in the last 5 years? . . . . . (Y)ES ☐ (N)O ☐

If YES, specify where. _____

(MST-) What is your marital status?

☐ (K)ever married ☐ (S)eparated ☐ (W)idow(er)
☐ (M)arried ☐ (D)ivorced

(CV-) Are you a veteran or currently in the Armed Forces? . . . . . (Y)ES ☐ (N)O ☐

(RMS-) Have you ever been rejected for military service because of physical, mental, or other reasons? (SF 93/22). . . . . (Y)ES ☐ (N)O ☐

If YES, give date and reason for rejection.

_____

(DMS-) Have you ever been discharged from military service because of physical, mental, or other reasons? (SF 93/23) . . . . . (Y)ES ☐ (N)O ☐

If YES, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.

_____
_____

SMOKING - CIGARETTES

(MSEG-) Do you now or have you ever smoked cigarettes?. . . . . (Y)ES ☐ (N)O ☐

If NO, go to the next section on SMOKING - PIPES AND CIGARS.

(BSC) *If YES*, at what age did you begin? *Specify age* __ __

(SMC-) Do you smoke now?. . . . . (Y)ES ☐ (N)O ☐

(AQS) If you have quit, at what age did you do so? *Specify age* __ __

(PCS-) How much do/did you smoke (on the average)?

☐ (A) Less than 1 pack per day ☐ (C) More than 1 pack, but less than 2 packs per day
☐ (B) One pack per day ☐ (D) More than 2 packs per day

(SWJ-) Do you smoke while on the job? . . . . . (Y)ES ☐ (N)O ☐

SMOKING - PIPES AND CIGARS

(SPC-) Do you smoke a pipe or cigars?. . . . . (Y)ES ☐ (N)O ☐

If NO, go to the next section on EXERCISE.

(YPC) How many years have you smoked a pipe or cigars? *Specify years* __ __

(IHS-) Do you inhale when smoking a pipe or cigars? . . . . . (Y)ES ☐ (N)O ☐ NOT (S)URE ☐

PERSONAL HISTORY (PH) (CONT.)

EXERCISE

Check one box for each question unless otherwise indicated.

		(Y)ES	(N)O	NOT (S)URE
(ASP-)	Do you exercise or engage in active sports REGULARLY (such as jogging, cycling, swimming, dancing, etc.)?	☐	☐	☐

(TPW-) *If YES*, how many times a week do you do that?

☐ (A) Less than 1 ☐ (C) 2 ☐ (E) 4 or more
☐ (B) 1 ☐ (D) 3

(LAJ-) What is your usual level of activity on your job?

☐ (S)edentary (mostly sitting)
☐ (M)oderate (some sitting, some walking)
☐ (A)ctive (active physical labor)

ALCOHOL

Check one box for each question unless otherwise indicated.

		(Y)ES	(N)O
(DBV-)	Do you drink alcoholic beverages (liquor, wine, beer)?	☐	☐

If NO, go to the next section on the SKIN.

If YES, how often do you drink each of the following types of drinks?

Check one box for each type of drink.

		(A) None	(B) Less than one day per week	(C) 1-2 days per week	(D) 3-4 days per week	(E) 5-7 days per week
(BEER-)	Beer	☐	☐	☐	☐	☐
(WINE-)	Wine	☐	☐	☐	☐	☐
(LIQ-)	Liquor	☐	☐	☐	☐	☐

(AAB-) On each day that you drink an alcoholic beverage, about how much do you usually drink? (If you drink more than one kind of alcoholic beverage, give the total number of beers plus glasses of wine plus number of highballs or cocktails.)

☐ (A) 1-2 ☐ (C) 5-6 ☐ (E) 9 or more
☐ (B) 3-4 ☐ (D) 7-8

		(Y)ES	NOT (S)URE	(N)O
(DKP-)	Do you or does a person close to you consider your drinking to be a problem?	☐	☐	☐
	If YES or NOT SURE, do you wish to speak to a doctor or nurse in private about obtaining counseling?	☐	☐	☐

REVIEW OF SYSTEMS (ROS)

SKIN

Check one box for each question unless otherwise indicated.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

		(Y)ES	NO (S)URE	(N)O
(SRS-)	A rash (including hives)?	☐	☐	☐
(CZ-)	*If YES or NOT SURE, what was/were the cause(s) of the skin rash? Check ALL that apply.*			

☐ (C)lothing ☐ (M)edicine ☐ (W*) Something in the workplace *(Specify)*_____
☐ (J)ewelry ☐ Sun(l)ight
☐ (S)oap ☐ (F)ood ☐ (O*) Cause other than previously listed *(Specify)*_____
☐ (T)oiletries or cosmetics ☐ (P)oison Ivy
☐ (U) Cause unknown or not certain

		(Y)ES	NOT (S)URE	(N)O
(MLS-)	Moles that have changed in size or color, or that have not healed?	☐	☐	☐

DID A DOCTOR EVER TELL YOU THAT YOU HAD:

		(Y)ES	NOT (S)URE	(N)O
(SKD-)	Skin disease(s)? (SF 93/11-14)	☐	☐	☐
(DDS-)	*If YES or NOT SURE, specify the disease. Check ALL that apply.*			

☐ (P)soriasis ☐ (S)kin cancer ☐ (O*)ther *(Specify)*_____

		(Y)ES	NOT (S)URE	(N)O
(OSP-)	Do you now have or have you ever in the past had any skin problems not covered above?	☐	☐	☐

*If YES or NOT SURE, specify.*_____

FOR OFFICE USE ONLY
(SNG) ☐
All neg ans

EYES

Check one box for each question unless otherwise indicated.

		(Y)ES	NOT (S)URE	(N)O
(VSN-)	Do you now have vision in both eyes? (SF 93/10B)	☐	☐	☐

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

		(Y)ES	NOT (S)URE	(N)O
(ETR-)	Eye trouble? (SF 93/11-6)	☐	☐	☐
(SYJ-)	Serious eye injury (more than 2 days off work)?	☐	☐	☐
(ESG-)	Eye surgery?	☐	☐	☐
(FQI-)	Frequent eye infections (e.g., conjunctivitis, pink eye)?	☐	☐	☐
(SBR-)	Severe itching, burning, redness, or swelling of the eyelids?	☐	☐	☐

DID A DOCTOR EVER TELL YOU THAT YOU HAD:

		(Y)ES	NOT (S)URE	(N)O
(GLC-)	Glaucoma (pressure on the eyeball)?	☐	☐	☐
(CTR-)	Cataracts?	☐	☐	☐

		(Y)ES	NOT (S)URE	(N)O
(GLS-)	Do you wear glasses? (SF 93/10A)	☐	☐	☐
(CLS-)	Do you wear contact lenses? (SF 93/10A)	☐	☐	☐
(OYP-)	Do you now have or have you in the past year had any eye problem(s) not covered above?	☐	☐	☐

*If YES or NOT SURE, specify.*_____

FOR OFFICE USE ONLY
(YNG) ☐
All neg ans

REVIEW OF SYSTEMS (ROS) (CONT.)

EARS AND HEARING *Check one box for each question unless otherwise indicated.*

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

		(Y)ES	NOT (S)URE	(N)O
(EWTT-)	Ear, nose, or throat trouble? (SF 93/11-7).	☐	☐	☐
(DFH-)	Any difficulty hearing or a hearing loss? (SF 93/11-8).	☐	☐	☐
(RHLS-)	*If Y* , have you noticed a recent hearing loss?	☐	☐	☐
(HRGD-)	Worn a hearing aid? (SF 93/10C)	☐	☐	☐
(RBZ-)	Ringing or buzzing in your ears once a week or more?.	☐	☐	☐
(TRBZ-)	*If YES or NOT SURE,* how long have you had this? ☐ (A) Less than 2 months ☐ (B) 2-5 months ☐ (C) 6-23 months ☐ (D) 2 years or more			

		(Y)ES	NOT (S)URE	(N)O
(CDS-)	Constant discharge (drainage of fluid) from your ears, or frequent infections in your ears?.	☐	☐	☐
(RDS-)	Regularly engaged in these sports or hobbies: scuba diving, or shooting (firearms), chain sawing, snowmobiling, motorcycling, rock music, or others with loud noise?.	☐	☐	☐
(OED-)	Any other ear difficulty not covered above?	☐	☐	☐

*If YES or NOT SURE, specify.*_____

_____

FOR OFFICE USE ONLY
(MNG) ☐
All neg ans

NOSE THROAT SINUSES MOUTH TEETH GUMS *Check one box for each question unless otherwise indicated.*

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:

		(Y)ES	NOT (S)URE	(N)O
(HFV-)	Hay fever? (SF 93/11-12).	☐	☐	☐
(NCG-)	Nasal congestion, persistent running nose, sinus congestion, or sinusitis? (SF 93/11-11).	☐	☐	☐
(PNF-)	Painful, swollen, or bleeding gums, or tooth trouble? (SF 93/11-10)	☐	☐	☐
(OCP-)	Any other trouble with your nose, throat, sinuses, mouth, teeth, or gums not covered above?.	☐	☐	☐

*If YES or NOT SURE, specify.*_____

_____

FOR OFFICE USE ONLY
(EONG) ☐
All neg ans

REVIEW OF SYSTEMS (ROS) (CONT.)

RESPIRATORY SYSTEM *Check one box for each question unless otherwise indicated.*

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(FCD-) Frequent (more than 3 per year) or long-lasting (2 weeks or more) colds? (SF 93/II-9)	☐	☐	☐
(CHC-) Chronic cough (almost everyday)? (SF 93/II-20)	☐	☐	☐

(AYC-) *If YES or NOT SURE*, during how many months of the year do you have this cough?

☐ (A) Less than 3 months ☐ (B) 3-6 months ☐ (C) More than 6 months

(LTC-) *If YES or NOT SURE*, how long have you had this cough?

☐ (A) Less than 2 years ☐ (B) 2-5 years ☐ (C) More than 5 years

(CRB-) *If YES or NOT SURE*, do you ever cough up red blood? (SF 93/9B)

☐ (Y) Yes ☐ (N) No

	(Y)ES	NOT (S)URE	(N)O
(TCW-) Tightness of the chest or wheezing?	☐	☐	☐

DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S)URE	(N)O
(ASH-) Asthma? (SF 93/II-17)	☐	☐	☐
(EMC-) Emphysema or chronic bronchitis?	☐	☐	☐
(TB-) Tuberculosis (TB)? (SF 93/II-16)	☐	☐	☐

	(Y)ES	NOT (S)URE	(N)O
(RTW-) Do you notice that when you return to work after being away for a few days (weekend or holiday) you get coughing, wheezing, or tightness of the chest?	☐	☐	☐
(LWT-) Have you ever lived with anyone who had tuberculosis (TB)? (SF 93/9A)	☐	☐	☐
(CRP-) Do you <u>now</u> have <u>or</u> have you ever in the <u>past</u> had any other respiratory or breathing problem(s) not covered above?	☐	☐	☐

If YES or NOT SURE, specify. _____

_____

FOR OFFICE USE ONLY

(RSNG) ☐

All neg ans

CARDIOVASCULAR SYSTEM *Check one box for each question unless otherwise indicated.*

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(SHB-) Shortness of breath (not the normal kind with severe exercise)? (SF 93/II-18)	☐	☐	☐
(TPC-) Tightness, pain, heaviness, squeezing, or pressure in your chest? (SF 93/II-19)	☐	☐	☐
(PLP-) Palpitations, pounding heart, or irregular heart beats (other than when you were upset, excited, or exercising)? (SF 93/II-21)	☐	☐	☐

DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S)URE	(N)O
(HBP-) High blood pressure (hypertension)? (SF 93/II-23)	☐	☐	☐
(LBP-) Low blood pressure? (SF 93/II-23)	☐	☐	☐
(HTR-) Heart trouble? (SF 93/II-22)	☐	☐	☐
(STRK-) A stroke?	☐	☐	☐
(PHLB-) Phlebitis (<u>deep</u> vein trouble in the legs)?	☐	☐	☐
(SFV-) Scarlet fever or erysipelas? (SF 93/II-1)	☐	☐	☐
(RHF-) Rheumatic fever? (SF 93/II-2)	☐	☐	☐

	(Y)ES	NOT (S)URE	(N)O
(LWK-) Do you limit your walking because of leg pain (cramps in your legs)? (SF 93/II-24)	☐	☐	☐
(HCP-) Do you <u>now</u> have <u>or</u> have you ever in the <u>past</u> had any other problem(s) with your heart or blood vessels not <u>covered</u> above?	☐	☐	☐

If YES or NOT SURE, specify. _____

_____

FOR OFFICE USE ONLY

(CNG) ☐

All neg ans

REVIEW OF SYSTEMS (ROS) (CONT.)

GASTROINTESTINAL SYSTEM *Check one box for each question unless otherwise indicated.*

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(FQD-) Frequent indigestion? (SF 93/11-25)	☐	☐	☐
(SMH-) Stomach trouble? (SF 93/11-26)	☐	☐	☐
(BTB-) Black, tar-colored, or bloody bowel movements?	☐	☐	☐
(CBH-) A change in your bowel habits (not explained by diet)?	☐	☐	☐
(HMP-) Hemorrhoids (piles) or rectal trouble? (SF 93/11-33)	☐	☐	☐

DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S)URE	(N)O
(DSU-) An ulcer (duodenal, stomach, or peptic)?	☐	☐	☐
(DSG-) Gallbladder trouble or gallstones? (SF 93/11-27)	☐	☐	☐
(DSJ-) Jaundice, hepatitis, or liver trouble? (SF 93/11-26&28)	☐	☐	☐
(DTR-) Intestinal trouble (includes diseases of the colon)? (SF 93/11-26)	☐	☐	☐

	(Y)ES	NOT (S)URE	(N)O
(OGP-) Do you now have or have you ever in the past had any other trouble(s) or disease(s) of the gastrointestinal system not covered above?	☐	☐	☐

If YES or NOT SURE, specify. _____

FOR OFFICE USE ONLY
(GNG) ☐
All neg ans

URINARY AND REPRODUCTIVE SYSTEMS *Check one box for each question unless otherwise indicated.*

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(BDB-) Bloody or dark brown urine (not dark yellow)? (SF 93/11-36)	☐	☐	☐
(PPU-) Frequent or painful urination? (SF 93/11-34)	☐	☐	☐
(FBK-) Frequent bladder or kidney infections?	☐	☐	☐
(PSD-) [MEN ONLY] Pain, swelling, or disease in your testicles?	☐	☐	☐

	(Y)ES	NOT (S)URE	(N)O
(FDS-) [WOMEN ONLY] Have you ever been treated for a female disorder? (SF 93/12A)	☐	☐	☐
(MSP-) [WOMEN ONLY] Have you ever had a change in menstrual pattern? (SF 93/12B)	☐	☐	☐

DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S)URE	(N)O
(DKS-) Kidney stones ("gravel" in your urine)? (SF 93/11-36)	☐	☐	☐
(DVD-) Venereal disease ("VD") of any kind (including syphilis, gonorrhea, etc.)? (SF 93/11-38)	☐	☐	☐

If YES or NOT SURE, specify the disease. _____

	(Y)ES	NOT (S)URE	(N)O
(ORU-) Do you now have or have you ever in the past had any problem(s) or disease(s) of the kidney, bladder, or reproductive system not covered above?	☐	☐	☐

If YES or NOT SURE, specify. _____

FOR OFFICE USE ONLY
(URG) ☐
All neg ans

(TRK-) Have you ever tried to have children and had difficulty?
☐ (Y)es, had difficulty ☐ Not (s)ure ☐ (N)o difficulty

(HCH-) Have you ever had any children (do not include foster children or adopted children)?
☐ (Y)es ☐ Not (s)ure ☐ (N)o

(CHM-) *If YES or NOT SURE,* have you ever had a child who was malformed (congenital malformation, birth defect)?
☐ (Y)es ☐ Not (s)ure ☐ (N)o

REVIEW OF SYSTEMS (ROS) (CONT.)

MUSCULOSKELETAL SYSTEM *Check one box for each question unless otherwise indicated.*

	DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(RBP-)	Recurrent back or neck pain so severe that it prevented you from performing your normal activities? (SF 93/11-45)	☐	☐	☐
(LNB-)	*If YES or NOT SURE, where was the pain located? Check ALL that apply.* ☐ (L)ower back ☐ (U)pper back ☐ (N)eck			
(BBS-)	To wear a brace or back support? (SF 93/10E)	☐	☐	☐
(BSG-)	Back surgery?	☐	☐	☐
	If YES or NOT SURE, specify.			
(HRP-)	Herniated or ruptured disc in your back?	☐	☐	☐
(SPJ-)	Swollen or painful joints? (SF 93/11-3)	☐	☐	☐
(DBJ-)	Deformity of bones or joints? (SF 93/11-41)	☐	☐	☐
(PTS-)	Painful or "trick" shoulder or elbow? (SF 93/11-44)	☐	☐	☐
(PTK-)	Painful, "trick", or locked knee, or knee that gives away? (SF 93/11-46)	☐	☐	☐
(KSG-)	Knee surgery?	☐	☐	☐
(LMN-)	Lameness (inability to walk normally because of foot or leg difficulty)? (SF 93/11-42)	☐	☐	☐
(FTR-)	Foot trouble? (SF 93/11-47)	☐	☐	☐
(LFT-)	Loss of finger or toe? (SF 93/11-43)	☐	☐	☐
(HFX-)	Fracture(s) (broken bones)? (SF 93/11-30)	☐	☐	☐
	DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S)URE	(N)O
(ARB-)	Arthritis, rheumatism, or bursitis? (SF 93/11-40)	☐	☐	☐
(SMT-)	Serious muscle or tendon injury (tendonitis)?	☐	☐	☐
(RPH-)	Rupture (hernia)? (SF 93/11-32)	☐	☐	☐
	If YES or NOT SURE, indicate year(s).			
	HAVE YOU EVER HAD MORE THAN ONE YEAR EXPERIENCE (AT WORK OR WHILE ENGAGED IN A HOBBY OR RECREATIONAL ACTIVITY) WITH ANY OF THE FOLLOWING:	(Y)ES	NOT (S)URE	(N)O
(HRL-)	Heavy, awkward, or repetitive lifting?	☐	☐	☐
(VBT-)	Vibrating tools (jackhammer, sander, etc.)?	☐	☐	☐
(RHW-)	Highly repetitive hand/wrist motion such as that required in certain types of hand tool or assembly operations?	☐	☐	☐
(MPC-)	*If YES or NOT SURE* to any of the three questions above, have you had any medical problems (pain, limitation of motion, etc.) connected with these activities?	☐	☐	☐
	If YES or NOT SURE, please describe.			
		(Y)ES	NOT (S)URE	(N)O
(NTF-)	Do you have any numbness or tingling in your fingers?	☐	☐	☐
(PWG-)	Do you have any pain in your hands, wrists, or forearms, particularly when grasping?	☐	☐	☐
(OMP-)	Do you now have or have you ever in the past had any other musculoskeletal problem(s) not covered above?	☐	☐	☐
	If YES or NOT SURE, specify.			

FOR OFFICE USE ONLY
(MSNG) ☐
All neg ans

REVIEW OF SYSTEMS (ROS) (CONT.)

NERVOUS SYSTEM — *Check one box for each question unless otherwise indicated.*

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(FQH-) Frequent or severe headaches? (SF 93/11-4)	☐	☐	☐
(DFB-) Dizziness, fainting spells, or blackouts? (SF 93/11-5)	☐	☐	☐
(PRC-) Periods of unconsciousness? (SF 93/11-56)	☐	☐	☐
(PLY-) Paralysis (including polio)? (SF 93/11-49)	☐	☐	☐
(SHK-) Shaking, tremor, or trembling of the hands (except when you were temporarily frightened or upset)?	☐	☐	☐
(EPZ-) Epilepsy or seizures ("fits")? (SF 93/11-50)	☐	☐	☐
(HJC-) Head injury resulting in loss of consciousness? (SF 93/11-13)	☐	☐	☐
(NRT-) Neuritis? (SF 93/11-48)	☐	☐	☐
(MSK-) Motion sickness (car, train, sea, or air sickness)? (SF 93/11-51)	☐	☐	☐
(TSC-) Attempted suicide? (SF 93/9D)	☐	☐	☐
(WLK-) Walking in your sleep? (SF 93/9E)	☐	☐	☐
(MNS-) Amnesia (loss of memory)? (SF 93/11-54)	☐	☐	☐
(FTS-) Frequent trouble sleeping? (SF 93/11-52)	☐	☐	☐
(DPW-) Depression or excessive worrying? (SF 93/11-53)	☐	☐	☐
(STM-) A problem with stuttering or stammering? (SF 93/10D)	☐	☐	☐
(PSY-) Treatment for a psychiatric (mental) condition? (SF 93/16)	☐	☐	☐

If YES or NOT SURE, specify where, year, and give details.

_____

_____

(ONP-) Other nervous trouble(s) of any sort not covered above? (SF 93/11-55)	☐	☐	☐

If YES or NOT SURE, specify. _____

_____

FOR OFFICE USE ONLY

(NNG) ☐ All neg ans

(HKD-) Are you: (SF 93/14)

☐ (R)ight handed ☐ (L)eft handed

MISCELLANEOUS — *Check one box for each question unless otherwise indicated.*

DID A DOCTOR EVER TELL YOU THAT YOU HAD:	(Y)ES	NOT (S, RE	(N)O
(DBS-) Diabetes (or sugar in your urine)? (SF 93/11-37)	☐	☐	☐
(TTG) Thyroid trouble or goiter? (SF 93/11-15)	☐	☐	☐
(DGT-) Gout?	☐	☐	☐
(DSN-) Anemia?	☐	☐	☐
(DCA-) Cancer of any kind? (SF 93/11-31)	☐	☐	☐

(KCA-) *If YES or NOT SURE, what kind of cancer? Check ALL that apply.*

☐ (S)kin ☐ Sto(m)ach ☐ (B)lood (Leukemia) ☐ Blu(d)der
☐ (H)ead or neck ☐ (C)olon ☐ L(y)mph (Hodgkins) ☐ (K)idney
☐ (E)sophagus ☐ (L)ung

MEN ONLY: ☐ (P)rostate ☐ (T)esticle

WOMEN ONLY: ☐ B(r)east ☐ Cervi(x) ☐ (U)terus ☐ O(v)ary

MEN OR WOMEN: ☐ (OO)ther *(Specify)* _____

REVIEW OF SYSTEMS (ROS) (CONT.)

MISCELLANEOUS (CONT.) *Check one box for each question unless otherwise indicated.*

		(Y)ES	NOT (S)URE	(N)O
(TGC-)	Did you ever have a noncancerous tumor, growth, or cyst? (SF 93/11-31)	☐	☐	☐

If YES or NOT SURE, specify where [body part(s)] and when [year(s)]. _____

		(Y)ES	NOT (S)URE	(N)O
(CWT-)	In the past 12 months have you had a change in your weight?	☐	☐	☐

(WCH-) *If YES or NOT SURE*, weight gain or loss? (SF 93/11-39)

☐ (A) Weight gain ☐ (B) Weight loss

(LBS-) *If YES or NOT SURE*, how much?

☐ (A) Less than 10 lbs. ☐ (C) 20-29 lbs. ☐ (E) 40 lbs. or more

☐ (B) 10-19 lbs. ☐ (D) 30-39 lbs.

DO YOU NOW HAVE OR HAVE YOU EVER IN THE PAST HAD:	(Y)ES	NOT (S)URE	(N)O
(BWT-) A problem with bed wetting (after age 12)? (SF 93/11-35)	☐	☐	☐
(XB-) Excessive (too much) bleeding from a small cut or after having a tooth pulled? (SF 93/9C)	☐	☐	☐
(FNB-) Frequent nose bleeds?	☐	☐	☐

FOR OFFICE USE ONLY

(NNG) ☐

All neg ans

		(Y^O)ES	(N)O
(ILJ-)	Have you ever had any illness or injury other than those already noted? (SF 93/20)	☐	☐

If YES, specify when, where, and give details. _____

		(Y^A)ES	(N)O
(DLI-)	Have you ever been denied life insurance? (SF 93/17)	☐	☐

If YES, state the reason and give details. _____

		(Y^E)ES	(N)O
(EXD-)	Have you ever received, is there pending, or have you applied for pension or compensation for an existing disability? (SF 93/24)	☐	☐

If YES, specify what kind, granted by whom, what amount, when, and why. _____

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY

OCCHX
OEI/ENV

Please answer the following questions about your general occupational and environmental exposures as best you can. Afterwards, the nurse or doctor will go over your answers with you in private.

NOTE: All of this information remains part of your confidential medical record. It can be released only by your signed permission. The information will be used to help provide better medical services to you.

OFFICE USE ONLY

SOCIAL SECURITY NUMBER	TODAY'S DATE	PROVIDER NO. 1	PROVIDER NO. 2
___-__-____	MONTH / DAY / YEAR	LAST NAME	LAST NAME

SITE OF ENCOUNTER	TYPE	VISIT CLASSIFICATION *(OFFICE USE ONLY)*
(A) North Island	(W) Occupational History for Job Number 1 of ____ *(OFFICE USE ONLY)*	☐ (10) Reviewed ☐ (11) Not Reviewed

OCCUPATIONAL EXPOSURE INVENTORY (OEI)

(OWK-) Have you ever been off work for more than a day because of an illness or injury related to work? *Check only one.*

☐ (Y*) Yes *(Please describe below.)*
☐ (S*) Not Sure

DO NOT WRITE IN THIS BOX

☐ (N) No

(RSH-) Have you ever worked with any substance that caused you to break out in a rash? *Check only one.*

☐ (Y*) Yes *(Please describe below.)*
☐ (S*) Not Sure

DO NOT WRITE IN THIS BOX

☐ (N) No

(CJ-) Have you ever changed jobs or work assignments because of any health problem(s) or injury(ies)? *Check only one.*

☐ (Y*) Yes *(Please describe below.)*
☐ (S*) Not Sure

DO NOT WRITE IN THIS BOX

☐ (N) No

(RMP-) Have you been refused employment or been unable to hold a job or stay in school because of: *Check ALL that apply.* (SF 93-15)

☐ (A) Sensitivity to chemicals, dust, sunlight, etc.
☐ (B) Inability to perform certain motions.
☐ (C) Inability to assume certain positions.
☐ (D*) Other medical reasons *(If checked, give reasons.)*

NHRC [11-6-84]

OCCUPATIONAL EXPOSURE INVENTORY (OEI) (CONT.)

(TBR-) Have you ever worked at a job that caused you trouble with breathing (includes cough, shortness of breath, or wheezing)? *Check only one.*

☐ (Y*) Yes *(Please list jobs and describe below.)*
☐ (S*) Not Sure

DO NOT WRITE IN THIS BOX

☐ (N) No

(PDB-) Do you frequently have pain or discomfort in your back, or have you been under professional care for back problems in the past year? *Check only one.*

☐ (Y*) Yes *(Please describe below.)*
☐ (S*) Not Sure

DO NOT WRITE IN THIS BOX

☐ (N) No

(VWC-) Did you ever receive compensation (VA, Workman's, etc.) for any of the above health problem(s) or injury(ies)? *Check only one.*

☐ (Y) Yes ☐ (S) Not Sure ☐ (N) No

ENVIRONMENTAL HISTORY (ENV)

(CRH-) Have you ever changed your residence or home because of a health problem?

☐ (N) No ☐ (Y*) *(If Yes, describe briefly.)*

(LNP-) Do you live next door to or very near an industrial plant?

☐ (N) No ☐ (Y*) *(If Yes, describe briefly.)*

(SHM-) Does your spouse or any other household member have contact with dusts or chemicals at work or during leisure activities?

☐ (N) No ☐ (Y*) *(If Yes, describe briefly.)*

(UPH-) Do you use pesticides and/or herbicides around your home or garden?

☐ (N) No ☐ (Y*) *(If Yes, describe briefly.)*

Which of the following do you have in your home? *Check All that apply.*

☐ ACD Air Conditioner
☐ APF Air Purifier
☐ HMF Humidifier
☐ GST Gas Stove
☐ EST Electric Stove
☐ IB Indoor Barbecue
☐ MCW Microwave Oven
☐ FPL Fireplace
☐ WBS Wood-burning Stove
☐ CBS Coal-burning Stove
☐ KST Kerosene Stove
☐ CHT Central Heating
☐ HHO Other *(Specify)*

ENVIRONMENTAL HISTORY (ENV) (CONT.)

(EHC-) Do you now have or have you ever had a hobby or craft? *Check only one.*

☐ (Y) Yes ☐ (S) Not Sure ☐ (N) No

If you have never had a hobby or craft, go to the CHRONOLOGICAL OCCUPATIONAL PROFILE on page 4.

If you have or have had a hobby or craft, complete one box below for each hobby or craft.

BOX 1	BOX 2	BOX 3
(NC1) Name of hobby or craft: _____	(NC2) Name of hobby or craft: _____	(NC3) Name of hobby or craft: _____
(YC1) How many years did you do/ have you done this hobby or craft? _____ Years	(YC2) How many years did you do/ have you done this hobby or craft? _____ Years	(YC3) How many years did you do/ have you done this hobby or craft? _____ Years
(HC1) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk	(HC2) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk	(HC3) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk
BOX 4	**BOX 5**	**BOX 6**
(NC4) Name of hobby or craft: _____	(NC5) Name of hobby or craft: _____	(NC6) Name of hobby or craft: _____
(YC4) How many years did you do/ have you done this hobby or craft? _____ Years	(YC5) How many years did you do/ have you done this hobby or craft? _____ Years	(YC6) How many years did you do/ have you done this hobby or craft? _____ Years
(HC4) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk	(HC5) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk	(HC6) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk
BOX 7	**BOX 8**	**BOX 9**
(NC7) Name of hobby or craft: _____	(NC8) Name of hobby or craft: _____	(NC9) Name of hobby or craft: _____
(YC7) How many years did you do/ have you done this hobby or craft? _____ Years	(YC8) How many years did you do/ have you done this hobby or craft? _____ Years	(YC9) How many years did you do/ have you done this hobby or craft? _____ Years
(HC7) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk	(HC8) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk	(HC9) On the average, how many hours per week did you do/ have you done this hobby or craft? _____ Hrs per Wk

For all the hobbies or crafts you have or have had, check the hazardous substances you come/came in contact with by breathing, touching, or direct exposure while doing these hobbies or crafts.

☐ (NHZ) No hazards that I know of

☐ HACD Acids
☐ HALC Alcohols (industrial)
☐ HASB Asbestos
☐ HFG Fibrous glass
☐ HHT Heat (severe)
☐ HNS Noise (loud)
☐ HSP Silica powder or sand-blasting dust
☐ HSL Solvents
☐ HVB Vibration
☐ HWF Welding fumes
☐ HOS Other substance(s) *(Specify)* _____

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) FOR CURRENT JOB

Complete this section for your current job as best you can. If you are unemployed, complete this section for your last job.

EMPLOYMENT STATUS

(NCE) Name of employer: _____

(CSC) City, State or Country: _____

(TND) Type of industry: _____

(HPW) Average number of hours worked per week: _____

(YS) Year started 19 __

(TNW) Total years worked there: _____

(YL) Year left: 19 __

(TMW) Total months worked there (if less than one year): _____

(STL) ☐ *Check box if* Still employed

(YJT) What is/was your job title? *(List ALL if more than one job title.)*

1. _____
2. _____
3. _____
4. _____

(DJ) Briefly describe the duties of your job for each job title listed above.

1. _____
2. _____
3. _____
4. _____

JOB-RELATED HEALTH PROBLEMS OR INJURIES

(JRH-) While on this job, have you had/did you have any job-related health problems or injuries?

☐ (Y*) Yes ☐ (S*) Not Sure ☐ (N) No

If yes or not sure, briefly describe each problem or injury. DO NOT WRITE IN THIS BOX

1. _____
2. _____
3. _____
4. _____

(CJP-) If yes or not sure, do/did any of your co-workers have health problems or injuries while on this same job?

☐ (Y*) Yes ☐ (S*) Not Sure ☐ (N) No

If your co-workers have/had health problems or injuries, briefly describe each problem or injury. DO NOT WRITE IN THIS BOX

1. _____
2. _____
3. _____
4. _____

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) FOR CURRENT JOB (CONT.)

HEALTH HAZARDS

What known health hazards are/were present on this job? *Check the appropriate boxes. Leave the boxes blank if the hazard was not present or if you are not sure that the hazard was present.*

		(A) Check here if health hazard is/was present on the job.	(B) Also check here if you are/were in direct contact with it by breathing, touching, or other direct exposure.	Indicate how long you have been/were directly or indirectly exposed to the health hazard. YEARS *(Use whole numbers; no ranges)*	MONTHS *(Use whole numbers; no ranges)*
(KHF-)	Fibrous glass (fiberglass)	☐	☐		
(KHA-)	Asbestos	☐	☐		
(KHC-)	Coal dust or rock dust	☐	☐		
(KHS-)	Silica powder or sandblasting dust	☐	☐		
(KHO-)	Other specific dusts (wood,talc,lime)	☐	☐		
(KHR-)	Respiratory or skin irritants	☐	☐		
(KHCH-)	Chemicals (acids,alkalis,solvents)	☐	☐		
(KHM-)	Metal fumes (from molten metal)	☐	☐		
(KHV-)	Welding fumes	☐	☐		
(KHL-)	Coal tar, pitch, asphalt	☐	☐		
(KHE-)	Engine exhaust, grease, oils, fuel	☐	☐		
(KHH-)	Heat (severe)	☐	☐		
(KHLD-)	Cold (severe)	☐	☐		
(KHN-)	Noise (loud)	☐	☐		
(KHZ-)	Non-ionizing radiation	☐	☐		
(KHX-)	Ionizing radiation (Xrays,etc.)	☐	☐		
(KHV-)	Vibration (vibrating tools,motors)	☐	☐		
(KHG-)	General shop dust	☐	☐		
(KHP-)	Pesticides, herbicides	☐	☐		
(KHO1-)	Other *(Write in)* _____	☐	☐		
(KHO2-)	Other *(Write in)* _____	☐	☐		
(KHO3-)	Other *(Write in)* _____	☐	☐		
(KHO4-)	Other *(Write in)* _____	☐	☐		

(NPH) ☐ *Check here if there are/were* No health hazards on this job

If you did not check Chemicals in the question above, go to the section on PROTECTIVE EQUIPMENT on page 6.

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) FOR CURRENT JOB (CONT.)

HEALTH HAZARDS (CONT.)

If you checked Chemicals in the previous question, which of the following chemicals are/were you exposed to, directly or indirectly? *Check ALL that apply which you are sure you are/were exposed to.*

- ☐ CACD Acids
- ☐ CALC Alcohols (industrial)
- ☐ CALK Alkalis (caustics)
- ☐ CAMM Ammonia
- ☐ CBNZ Benzene
- ☐ CBRY Beryllium
- ☐ CCDM Cadmium
- ☐ CCOX Calcium oxide (lime dust)
- ☐ CCBM Carbon monoxide
- ☐ CCT Carbon tetrachloride
- ☐ CCN Chlorinated naphthalene
- ☐ CCLF Chloroform
- ☐ CCLP Chloroprene
- ☐ CCHM Chromates
- ☐ CDB Dichlorobenzene
- ☐ CEDB Ethylene dibromide (EDB)
- ☐ CHT Halothane
- ☐ CISC Isocyanates, methylene dipnenyl isocyanate (MDI), or toluene diisocyanate (TDI)
- ☐ CKT Ketones
- ☐ CLD Lead (inorganic)
- ☐ CMS Manganese
- ☐ CMR Mercury (inorganic)
- ☐ CMT Methylene chloride
- ☐ CNK Nickel (inorganic)
- ☐ CP Perchloroethylene
- ☐ CPN Phenol
- ☐ CPS Phosgene
- ☐ CPBB Polybrominated biphenyls (PBB's)
- ☐ CPCB Polychlorinated biphenyls (PCB's)
- ☐ CSL Solvents
- ☐ CST Styrene
- ☐ CTL Toluene
- ☐ CTE Trichloroethane ("T· e")
- ☐ CTEL Trichloroethylene
- ☐ CNS One of previous two; not sure which one.
- ☐ CINT Trinitrotoluene (TNT)
- ☐ CVC Vinyl chloride
- ☐ CTH Other *(Write in)* _____

Other *(Write in)* _____

Other *(Write in)* _____

Other *(Write in)* _____

Other *(Write in)* _____

Other *(Write in)* _____

Other *(Write in)* _____

Other *(Write in)* _____

Other *(Write in)* _____

Other *(Write in)* _____

PROTECTIVE EQUIPMENT

(PEQ-) Do/Did you use protective equipment while on this job?

☐ (Y) Yes ☐ (S) Not Sure ☐ (N) No

(TPQ-) If yes, which of the following do/did you use? *Check ALL that apply.*

- ☐ (A)pron
- ☐ (E)ar plugs, muffs, or cranial helmet
- ☐ (F)ace mask
- ☐ (G)loves
- ☐ (R)espirator
- ☐ (S)afety glasses
- ☐ S(u)it
- ☐ (O*)ther *(Specify)* _____

_____

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY
CHRONOLOGICAL OCCUPATIONAL PROFILE

OCCHX
COP

JOB #2

Now that you have completed a CHRONOLOGICAL OCCUPATIONAL PROFILE for your current job (or, if unemployed, for your last job), please fill out a CHRONOLOGICAL OCCUPATIONAL PROFILE for all jobs *(including military service)* that you had prior to that. Start with the job just before your current job or, if unemployed, your last job (this is JOB #2), and then work backwards to high school or age 18, whichever comes first.

OFFICE USE ONLY

SOCIAL SECURITY NUMBER	TODAY'S DATE	PROVIDER NO. 1	PROVIDER NO. 2
___ - __ - ____	__ / __ / __ MONTH DAY YEAR	LAST NAME	LAST NAME

SITE OF ENCOUNTER	TYPE	VISIT CLASSIFICATION *(OFFICE USE ONLY)*
(A) North Island	(X) Occupational History for Job Number 2 of ____ *(OFFICE USE ONLY)*	☐ (10) Reviewed ☐ (11) Not Reviewed

EMPLOYMENT STATUS

(NCE) Name of employer: _____

(TND) Type of industry: _____

(YS) Year started: 19 __

(YL) Year left: 19 __

(CSC) City, State or Country: _____

(HPW) Average number of hours worked per week: ___

(TNW) Total years worked there: _____

(TMW) Total months worked there (if less than one year): _____

(YJT) What was your job title? *(List ALL if more than one job title.)*

1. _____
2. _____
3. _____
4. _____

(DJ) Briefly describe the duties of your job for each job title listed above.

1. _____
2. _____
3. _____
4. _____

JOB-RELATED HEALTH PROBLEMS OR INJURIES

(JRH-) While on this job, did you have any job-related health problems or injuries?

☐ (Y*) Yes ☐ (S*) Not Sure ☐ (N) No

If yes or not sure, briefly describe each problem or injury.

1. _____
2. _____
3. _____
4. _____

DO NOT WRITE IN THIS BOX

(CJP-) If yes or not sure, did any of your co-workers have health problems or injuries while on this same job?

☐ (Y*) Yes ☐ (S*) Not Sure ☐ (N) No

If your co-workers had health problems or injuries, briefly describe each problem or injury.

1. _____
2. _____
3. _____
4. _____

DO NOT WRITE IN THIS BOX

NHRC (11-6-84)

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) (CONT.)

HEALTH HAZARDS

What known health hazards were present on this job? *Check the appropriate boxes. Leave the boxes blank if the hazard was not present or if you are not sure that the hazard was present.*

		(A) Check here if health hazard was present on the job.	(B) Also check here if you were in direct contact with it by breathing, touching, or other direct exposure.	Indicate how long you were directly or indirectly exposed to the health hazard. YEARS *(Use whole numbers; no ranges)*	MONTHS *(Use whole numbers; no ranges)*
(KHF-)	Fibrous glass (fiberglass)	☐	☐		
(KHA-)	Asbestos	☐	☐		
(KHC-)	Coal dust or rock dust	☐	☐		
(KHS-)	Silica powder or sandblasting dust	☐	☐		
(KHO-)	Other specific dusts (wood,talc,lime)	☐	☐		
(KHR-)	Respiratory or skin irritants	☐	☐		
(KHCK-)	Chemicals (acids,alkalis,solvents)	☐	☐		
(KHM-)	Metal fumes (from molten metal)	☐	☐		
(KHW-)	Welding fumes	☐	☐		
(KHL-)	Coal tar, pitch, asphalt	☐	☐		
(KHE-)	Engine exhaust, grease, oils, fuel	☐	☐		
(KHH-)	Heat (severe)	☐	☐		
(KHLD-)	Cold (severe)	☐	☐		
(KHN-)	Noise (loud)	☐	☐		
(KHZ-)	Non-ionizing radiation	☐	☐		
(KHX-)	Ionizing radiation (Xrays,etc.)	☐	☐		
(KHV-)	Vibration (vibrating tools,motors)	☐	☐		
(KHG-)	General shop dust	☐	☐		
(KHP-)	Pesticides, herbicides	☐	☐		
(KHO1-)	Other *(Write in)* _____	☐	☐		
(KHO2-)	Other *(Write in)* _____	☐	☐		
(KHO3-)	Other *(Write in)* _____	☐	☐		
(KHO4-)	Other *(Write in)* _____	☐	☐		

(NPH) ☐ *Check here if there were* No health hazards on this job

If you did not check Chemicals in the question above, go to the section on PROTECTIVE EQUIPMENT on the next page.

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) (CONT.)

HEALTH HAZARDS (CONT.)

If you checked Chemicals in the previous question, which of the following chemicals were you exposed to, directly or indirectly? *Check ALL that apply which you are sure you were exposed to.*

- ☐ CACD Acids
- ☐ CALC Alcohols (industrial)
- ☐ CALK Alkalis (caustics)
- ☐ CAMM Ammonia
- ☐ CBNZ Benzene
- ☐ CBRY Beryllium
- ☐ CCDM Cadmium
- ☐ CCOX Calcium oxide (lime dust)
- ☐ CCBM Carbon monoxide
- ☐ CCT Carbon tetrachloride
- ☐ CCN Chlorinated naphthalene
- ☐ CCLF Chloroform
- ☐ CCLP Chloroprene
- ☐ CCHM Chromates
- ☐ CDB Dichlorobenzene
- ☐ CEDB Ethylene dibromide (EDB)
- ☐ CHT Halothane
- ☐ CISC Isocyanates, methylene diphenyl isocyanate (MDI), or toluene diisocyanate (TDI)
- ☐ CKT Ketones
- ☐ CLD Lead (inorganic)
- ☐ CMS Manganese
- ☐ CMR Mercury (inorganic)
- ☐ CMT Methylene chloride
- ☐ CNK Nickel (inorganic)
- ☐ CP Perchloroethylene
- ☐ CPN Phenol
- ☐ CPS Phosgene
- ☐ CPBB Polybrominated biphenyls (PBB's)
- ☐ CPCB Polychlorinated biphenyls (PCB's)
- ☐ CSL Solvents
- ☐ CST Styrene
- ☐ CTL Toluene
- ☐ CTE Trichloroethane ("Trike")
- ☐ CTEL Trichloroethylene
- ☐ CNS One of previous two; not sure which one.
- ☐ CTNT Trinitrotoluene (TNT)
- ☐ CVC Vinyl chloride

☐ CTH Other *(Write in)* _____

Other *(Write in)* _____ Other *(Write in)* _____

Other *(Write in)* _____ Other *(Write in)* _____

Other *(Write in)* _____ Other *(Write in)* _____

Other *(Write in)* _____ Other *(Write in)* _____

Other *(Write in)* _____ Other *(Write in)* _____

PROTECTIVE EQUIPMENT

(PEQ-) Did you use protective equipment while on this job?

☐ (Y) Yes ☐ (S) Not Sure ☐ (N) No

(TPQ-) If yes, which of the following did you use? *Check ALL that apply.*

- ☐ (A)pron
- ☐ (E)ar plugs, muffs, or cranial helmet
- ☐ (F)ace mask
- ☐ (G)loves
- ☐ (R)espirator
- ☐ (S)afety glasses
- ☐ S(u)it
- ☐ (O*)ther *(Specify)*

_____

_____

OCCUPATIONAL HEALTH CARE
OCCUPATIONAL HISTORY
CHRONOLOGICAL OCCUPATIONAL PROFILE

OCCHX
COP

JOB #___

Now that you have completed a CHRONOLOGICAL OCCUPATIONAL PROFILE for your current job (or, if unemployed, for your last job), please fill out a CHRONOLOGICAL OCCUPATIONAL PROFILE for all jobs *(including military service)* that you had prior to that. Start with the job just before your current job or, if unemployed, your last job (this is JOB #2), and then work backwards to high school or age 18, whichever comes first.

OFFICE USE ONLY

SOCIAL SECURITY NUMBER	TODAY'S DATE	PROVIDER NO. 1	PROVIDER NO. 2
___-___-____	___/___/___ MONTH DAY YEAR	LAST NAME	LAST NAME

SITE OF ENCOUNTER	TYPE	VISIT CLASSIFICATION *(OFFICE USE ONLY)*
(A) North Island	(X) Occupational History for Job Number ___ of ___ *(OFFICE USE ONLY)*	☐ (10) Reviewed ☐ (11) Not Reviewed

EMPLOYMENT STATUS

(NCE) Name of employer: _____

(TND) Type of industry: _____

(YS) Year started: 1 9 ___ ___

(YL) Year left: 1 9 ___ ___

(CSC) City, State or Country: _____

(HPW) Average number of hours worked per week: _____

(TNW) Total years worked there: _____

(TMW) Total months worked there (If less than one year): _____

(YJT) What was your job title? *(List ALL if more than one job title.)*

1. _____
2. _____
3. _____
4. _____

(GJ) Briefly describe the duties of your job for each job title listed above.

1. _____
2. _____
3. _____
4. _____

JOB-RELATED HEALTH PROBLEMS OR INJURIES

(JRH-) While on this job, did you have any job-related health problems or injuries?

☐ (Y*) Yes ☐ (S*) Not Sure ☐ (N) No

If yes or not sure, briefly describe each problem or injury.

1. _____
2. _____
3. _____
4. _____

DO NOT WRITE IN THIS BOX

(CJP-) If yes or not sure, did any of your co-workers have health problems or injuries while on this same job?

☐ (Y*) Yes ☐ (S*) Not Sure ☐ (N) No

If your co-workers had health problems or injuries, briefly describe each problem or injury.

1. _____
2. _____
3. _____
4. _____

DO NOT WRITE IN THIS BOX

NHRC [11-6-84]

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) (CONT.)

HEALTH HAZARDS

What known health hazards were present on this job? *Check the appropriate boxes. Leave the boxes blank if the hazard was not present or if you are not sure that the hazard was present.*

		(A) Check here if health hazard was present on the job.	(B) Also check here if you were in direct contact with it by breathing, touching, or other direct exposure.	Indicate how long you were directly or indirectly exposed to the health hazard. YEARS *(Use whole numbers; no ranges)*	MONTHS *(Use whole numbers; no ranges)*
(KHF-)	Fibrous glass (fiberglass)	☐	☐		
(KHA-)	Asbestos	☐	☐		
(KHC-)	Coal dust or rock dust	☐	☐		
(KHS-)	Silica powder or sandblasting dust	☐	☐		
(KHD-)	Other specific dusts (wood,talc,lime)	☐	☐		
(KHR-)	Respiratory or skin irritants	☐	☐		
(KHCH-)	Chemicals (acids,alkalis,solvents)	☐	☐		
(KHM-)	Metal fumes (from molten metal)	☐	☐		
(KHW-)	Welding fumes	☐	☐		
(KHT-)	Coal tar, pitch, asphalt	☐	☐		
(KHE-)	Engine exhaust, grease, oils, fuel	☐	☐		
(KHH-)	Heat (severe)	☐	☐		
(KHLD-)	Cold (severe)	☐	☐		
(KHN-)	Noise (loud)	☐	☐		
(KHZ-)	Non-ionizing radiation	☐	☐		
(KHX-)	Ionizing radiation (Xrays,etc.)	☐	☐		
(KHV-)	Vibration (vibrating tools,motors)	☐	☐		
(KHG-)	General shop dust	☐	☐		
(KHP-)	Pesticides, herbicides	☐	☐		
(KHO1-)	Other *(Write in)* _____	☐	☐		
(KHO2-)	Other *(Write in)* _____	☐	☐		
(KHO3-)	Other *(Write in)* _____	☐	☐		
(KHO4-)	Other *(Write in)* _____	☐	☐		

(NPH) ☐ *Check here if there were* No health hazards on this job

If you did not check Chemicals in the question above, go to the section on PROTECTIVE EQUIPMENT on the next page.

CHRONOLOGICAL OCCUPATIONAL PROFILE (COP) (CONT.)

HEALTH HAZARDS (CONT.)

If you checked Chemicals in the previous question, which of the following chemicals were you exposed to, directly or indirectly? *Check ALL that apply which you are sure you were exposed to.*

- ☐ CACD Acids
- ☐ CALC Alcohols (industrial)
- ☐ CALK Alkalis (caustics)
- ☐ CAMM Ammonia
- ☐ CBNZ Benzene
- ☐ CBRY Beryllium
- ☐ CCD Cadmium
- ☐ CCOX Calcium oxide (lime dust)
- ☐ CCBM Carbon monoxide
- ☐ CCT Carbon tetrachloride
- ☐ CCN Chlorinated naphthalene
- ☐ CCLF Chloroform
- ☐ CCLP Chloroprene
- ☐ CCHM Chromates
- ☐ CDB Dichlorobenzene
- ☐ CEDB Ethylene dibromide (EDB)
- ☐ CHT Halothane
- ☐ CISC Isocyanates, methylene diphenyl isocyanate (MDI), or toluene diisocyanate (TDI)
- ☐ CKT Ketones
- ☐ CLD Lead (inorganic)
- ☐ CMS Manganese
- ☐ CMR Mercury (inorganic)
- ☐ CMT Methylene chloride
- ☐ CNK Nickel (inorganic)
- ☐ CP Perchloroethylene
- ☐ CPN Phenol
- ☐ CPS Phosgene
- ☐ CPBB Polybrominated biphenyls (PBB's)
- ☐ CPCB Polychlorinated biphenyls (PCB's)
- ☐ CSL Solvents
- ☐ CST Styrene
- ☐ CTL Toluene
- ☐ CTE Trichloroethane ("Trike")
- ☐ CTEL Trichloroethylene
- ☐ CNS One of previous two; not sure which one.
- ☐ CTNT Trinitrotoluene (TNT)
- ☐ CVC Vinyl chloride
- ☐ CTH Other *(Write in)* _____

Other *(Write in)* _____
Other *(Write in)* _____
Other *(Write in)* _____
Other *(Write in)* _____
Other *(Write in)* _____
Other *(Write in)* _____
Other *(Write in)* _____
Other *(Write in)* _____
Other *(Write in)* _____

PROTECTIVE EQUIPMENT

(PEQ-) Did you use protective equipment while on this job?

☐ (Y) Yes ☐ (S) Not Sure ☐ (N) No

(TPQ-) If yes, which of the following did you use? *Check ALL that apply.*

- ☐ (A)pron
- ☐ (E)ar plugs, muffs, or cranial helmet
- ☐ (F)ace mask
- ☐ (G)loves
- ☐ (R)espirator
- ☐ (S)afety glasses
- ☐ S(u)it
- ☐ (O*)ther *(Specify)* _____

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

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Approved for public release; distribution unlimited

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Approved for public release; distribution unlimited

18. SUPPLEMENTARY NOTES

19. KEY WORDS (Continue on reverse side if necessary and identify by block number)

Medical History Form
Occupational History Form
Environmental
Work-related
Non-work-related

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

This report describes the development of the medical and occuapational history forms in support of the Navy Occupational Health Information Management System (NOHIMS). The forms are presented in detail and discussed in terms of their importance in a computerized medical information system. The use of these forms will provide a comprehensive summary of an individual's medical, employment and exposure history throughout his or her adult life.

DD FORM 1 JAN 73 1473 EDITION OF 1 NOV 65 IS OBSOLETE

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