



Tetanus: No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_  
Hepatitis B series: No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_  
If yes, were you tested for antibody to Hepatitis B? No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_  
Rabies series: No \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_  
If yes, were you tested for antibody to Rabies? No \_\_\_\_\_ Yes \_\_\_\_\_ Titer \_\_\_\_\_ Date \_\_\_\_\_  
Measles/Mumps/Rubella: No \_\_\_\_\_ Yes \_\_\_\_\_ Dates \_\_\_\_\_

### **Tuberculosis Surveillance**

Have you ever lived outside the United States? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, list countries \_\_\_\_\_  
Have you received the tuberculosis vaccine Bacillus Calmette-Guerin (BCG) vaccination? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, have you had a Tb skin test after vaccination? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, list month/year and results of Tb skin test: positive \_\_\_\_\_ negative \_\_\_\_\_ Date \_\_\_\_\_  
Have you ever had active tuberculosis? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, list date and describe treatment \_\_\_\_\_  
If no, list month/year and results of Tb skin test: positive \_\_\_\_\_ negative \_\_\_\_\_ Date \_\_\_\_\_  
Do you have sensitivity or reaction to the Tb purified protein derivative used in the skin test? No \_\_\_\_\_ Yes \_\_\_\_\_  
Have you had radiographs taken related to Tb screening? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, list the reason radiograph was taken : \_\_\_\_\_

### **Allergy/Asthma**

Do you have asthma? No \_\_\_\_\_ Yes \_\_\_\_\_  
What are the causes of your asthma? \_\_\_\_\_  
Are you allergic to any animal? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, list animals: \_\_\_\_\_  
Do you have allergy symptoms/asthma related to animals that you currently work with? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, list animals: \_\_\_\_\_  
Do you have any other known allergies? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, please list: \_\_\_\_\_  
List the symptoms that occur related to these allergies: \_\_\_\_\_  
List treatments that you receive for allergy/asthma: \_\_\_\_\_  
Do you have skin problems related to work? (reactions to gloves, dry/cracked skin, rashes) No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, describe: \_\_\_\_\_  
Do you have a condition, or take medications, which could suppress your immune system? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, explain \_\_\_\_\_  
Do you have any ongoing medical conditions? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, explain: \_\_\_\_\_  
Do you have any health or workplace concerns not covered by this questionnaire that you feel may affect your occupational health, and would like to confidentially discuss with the Occupational Health Consultant or your Personal care physician? \_\_\_\_\_

### **For Women Only**

Are you currently pregnant? No \_\_\_\_\_ Yes \_\_\_\_\_  
Are you planning on becoming pregnant in the next year? No \_\_\_\_\_ Yes \_\_\_\_\_

I have answered the questions on this form truthfully and to the best of my ability and recollection.

Name (Print): \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Return this medical history to:  
Wipperman Occupational Health  
19567 Cleveland Road  
South Bend, IN 46637

OR

Place in a sealed envelope  
Label the envelope- Confidential Medical History  
Return to the FLSC office room 400