

History Form — Page 1 of 5

NOTE: PLEASE PRINT AND BE AS COMPLETE AS POSSIBLE. THIS INFORMATION WILL BE HELD IN CONFIDENCE AND WILL HELP TO PLACE YOU IN THE PROPER JOB.

Company Name				Date			
Name (Last, First, Middle)			Social Security Number			Date of Birth	
Address		City	State	Zip	Phone No.	Sex	Marital Status
In Emergency Notify		Address			Phone No.	Relationship	
Personal Physician		Address					

LIST ALL YOUR PREVIOUS JOBS (Start with your Last Job)

JOB	EMPLOYER	DATES		REASON FOR LEAVING
		FROM	TO	

CHECK THE HIGHEST GRADE YOU COMPLETED IN SCHOOL

ELEMENTARY								HIGH				COLLEGE				Your Age on Leaving School
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	

	YES	NO	IF YES, EXPLAIN BRIEFLY
Have you ever worked in a dusty atmosphere?			
Have you ever worked with radioactive materials?			
Have you ever worked with poisonous materials?			
Have you ever worked in a noisy environment?			
Have you ever worked with Lead, Beryllium, Arsenic, Mercury, Benzene?			
Have you ever required a special job assignment because of the effects of illness or injury?			
Have you ever been rejected for a job or have you lost a job or quit because of your health?			
Have you ever received compensation or cash settlement for injuries, disease, or other medical problems from an employer or insurance company?			
Have you ever filed a claim or have any claim pending for injuries or illness related to your work? If so, claim number: _____			
Have you ever served in the United States Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, GIVE	Dates (From - To)	Branch Theater Type of Discharge
Were you ever rejected for military service? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF Yes, why?		Have you ever filed a claim or received payment for disability from the government? <input type="checkbox"/> Yes <input type="checkbox"/> No

HAS ANY IMMEDIATE RELATIVE (Mother, Father, Brother, Sister, Wife, Husband, Children) EVER HAD:

	YES	NO	IF YES, WHAT RELATIONS	YES	NO	IF YES, WHAT RELATIONS	
Tuberculosis				Diabetes			
Cancer				Stroke			
Epilepsy or Seizures				Attempted Suicide			
Heart Trouble				Asthma, Hay Fever, or Other Allergy			

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NAME: _____

Please complete this questionnaire as it relates to your past exposures, both prior to and as related to your present employment.

OCCUPATIONAL EXPOSURE INVENTORY:

	YES	NO																																																	
1. Please describe any health problems or injuries you have experienced connected with your present or past jobs.																																																			
2. Have any of your co-workers also experienced health problems or injuries connected with the same jobs? If yes, please describe:																																																			
3. Do you or have you ever smoked cigarettes, cigars, pipes, or used oral tobacco? If so, which and how many/much per day?																																																			
4. Do you smoke while on the job, as a general rule?																																																			
5. Do you have any allergies or allergic condition? If so, please describe:																																																			
6. Have you ever worked with any substance which caused you to break out in a rash? If so, please describe your reaction and name the substance:																																																			
7. Have you ever been off work for more than a day because of an illness or injury related to work? If so, please describe.																																																			
8. Have you ever worked at a job which caused you trouble breathing, such as cough, shortness of breath, or wheezing? If so, please describe:																																																			
9. Have you ever changed jobs or work assignments because of any health problems or injuries? If so, please describe:																																																			
10. Do you frequently experience pain or discomfort in your lower back or have you been under a doctor's care for back problems? If so, please describe:																																																			
11. Have you ever worked at a job or hobby in which you came into direct contact with any of the following substances by breathing, touching, or direct exposure? If so, please check the box beside the substance.																																																			
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Acids</td> <td><input type="checkbox"/> Beryllium</td> <td><input type="checkbox"/> Chromates</td> <td><input type="checkbox"/> Heat (severe)</td> <td><input type="checkbox"/> Nickel</td> <td><input type="checkbox"/> Radiation</td> <td><input type="checkbox"/> Trichloroethylene</td> </tr> <tr> <td><input type="checkbox"/> Alcohols (industrial)</td> <td><input type="checkbox"/> Cadmium</td> <td><input type="checkbox"/> Coal dust</td> <td><input type="checkbox"/> Isocyanates</td> <td><input type="checkbox"/> Noise (loud)</td> <td><input type="checkbox"/> Rock Dust</td> <td><input type="checkbox"/> Trinitrotoluene</td> </tr> <tr> <td><input type="checkbox"/> Alkalis</td> <td><input type="checkbox"/> Carbon tetrachloride</td> <td><input type="checkbox"/> Dichlorobenzene</td> <td><input type="checkbox"/> Lead</td> <td><input type="checkbox"/> PBB's</td> <td><input type="checkbox"/> Silica Powder</td> <td><input type="checkbox"/> Vibration</td> </tr> <tr> <td><input type="checkbox"/> Ammonia</td> <td><input type="checkbox"/> Chlorinated naphthalenes</td> <td><input type="checkbox"/> Ethylene dibromide</td> <td><input type="checkbox"/> Manganese</td> <td><input type="checkbox"/> Perchloroethylene</td> <td><input type="checkbox"/> Styrene</td> <td><input type="checkbox"/> Welding fumes</td> </tr> <tr> <td><input type="checkbox"/> Arsenic</td> <td><input type="checkbox"/> Chloroform</td> <td><input type="checkbox"/> Fiberglass</td> <td><input type="checkbox"/> Mercury</td> <td><input type="checkbox"/> Pesticides</td> <td><input type="checkbox"/> Talc</td> <td><input type="checkbox"/> X-rays</td> </tr> <tr> <td><input type="checkbox"/> Asbestos</td> <td><input type="checkbox"/> Chloroprene</td> <td><input type="checkbox"/> Halothane</td> <td><input type="checkbox"/> Methylene chloride</td> <td><input type="checkbox"/> Phenol</td> <td><input type="checkbox"/> Toluene</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Benzene</td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Phosgene</td> <td><input type="checkbox"/> TDI or MDI</td> <td></td> </tr> </table>	<input type="checkbox"/> Acids	<input type="checkbox"/> Beryllium	<input type="checkbox"/> Chromates	<input type="checkbox"/> Heat (severe)	<input type="checkbox"/> Nickel	<input type="checkbox"/> Radiation	<input type="checkbox"/> Trichloroethylene	<input type="checkbox"/> Alcohols (industrial)	<input type="checkbox"/> Cadmium	<input type="checkbox"/> Coal dust	<input type="checkbox"/> Isocyanates	<input type="checkbox"/> Noise (loud)	<input type="checkbox"/> Rock Dust	<input type="checkbox"/> Trinitrotoluene	<input type="checkbox"/> Alkalis	<input type="checkbox"/> Carbon tetrachloride	<input type="checkbox"/> Dichlorobenzene	<input type="checkbox"/> Lead	<input type="checkbox"/> PBB's	<input type="checkbox"/> Silica Powder	<input type="checkbox"/> Vibration	<input type="checkbox"/> Ammonia	<input type="checkbox"/> Chlorinated naphthalenes	<input type="checkbox"/> Ethylene dibromide	<input type="checkbox"/> Manganese	<input type="checkbox"/> Perchloroethylene	<input type="checkbox"/> Styrene	<input type="checkbox"/> Welding fumes	<input type="checkbox"/> Arsenic	<input type="checkbox"/> Chloroform	<input type="checkbox"/> Fiberglass	<input type="checkbox"/> Mercury	<input type="checkbox"/> Pesticides	<input type="checkbox"/> Talc	<input type="checkbox"/> X-rays	<input type="checkbox"/> Asbestos	<input type="checkbox"/> Chloroprene	<input type="checkbox"/> Halothane	<input type="checkbox"/> Methylene chloride	<input type="checkbox"/> Phenol	<input type="checkbox"/> Toluene		<input type="checkbox"/> Benzene				<input type="checkbox"/> Phosgene	<input type="checkbox"/> TDI or MDI			
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If you have answered yes to any of the above, please describe your exposure on the back of this paper.																																																			

ENVIRONMENTAL INVENTORY:

	YES	NO							
1. Have you ever changed your residence or home because of a health problem? If so, please describe:									
2. Do you live next door or very near an industrial plant? If so, please describe.									
3. Do you have a hobby or craft which you do at home? If so, please describe:									
4. Does your spouse or any other household member have contact with dusts or chemicals at work or during leisure activities? If so, please describe:									
5. Do you use pesticides around your home or garden? If so, please describe.									
6. Which of the following do you have in your home? (Please check all that apply.)									
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Air Conditioner</td> <td><input type="checkbox"/> Air Purifier</td> <td><input type="checkbox"/> Humidifier</td> <td><input type="checkbox"/> Gas Stove</td> <td><input type="checkbox"/> Electric Stove</td> <td><input type="checkbox"/> Fireplace</td> <td><input type="checkbox"/> Central Heating</td> </tr> </table>	<input type="checkbox"/> Air Conditioner	<input type="checkbox"/> Air Purifier	<input type="checkbox"/> Humidifier	<input type="checkbox"/> Gas Stove	<input type="checkbox"/> Electric Stove	<input type="checkbox"/> Fireplace	<input type="checkbox"/> Central Heating		
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NAME: _____

Please complete this questionnaire as it relates to your past exposures, both prior to and as related to your present employment.

TOXIC EXPOSURE HISTORY:

Complete the following history. Begin with your most recent job.

Project Title: _____	Location: _____
Work Activities: _____	Time Spent in Field: _____
SUSPECT HAZARDOUS MATERIALS ON SITE: _____	
including physical (noise, vibration, _____	
radiation), chemical (metals, acids, _____	
solvents) and biological (viruses, _____	
bacteria, etc.), materials.	
Protective Equipement: _____	

Project Title: _____	Location: _____
Work Activities: _____	Time Spent in Field: _____
SUSPECT HAZARDOUS MATERIALS ON SITE: _____	
including physical (noise, vibration, _____	
radiation), chemical (metals, acids, _____	
solvents) and biological (viruses, _____	
bacteria, etc.), materials.	
Protective Equipement: _____	

Project Title: _____	Location: _____
Work Activities: _____	Time Spent in Field: _____
SUSPECT HAZARDOUS MATERIALS ON SITE: _____	
including physical (noise, vibration, _____	
radiation), chemical (metals, acids, _____	
solvents) and biological (viruses, _____	
bacteria, etc.), materials.	
Protective Equipement: _____	

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize investigation of all statements contained in this Medical History and do hereby release my prospective employer and AultWorks and my present and former employers, personal references named, or any other persons or organizations to whom my prospective employer and/or AultWorks may refer, from any liability for any damage as a result of providing or acting upon information regarding me. I understand that misrepresentation or admission of facts called for on this form is cause for subsequent dismissal.

Date	Signature of Examinee
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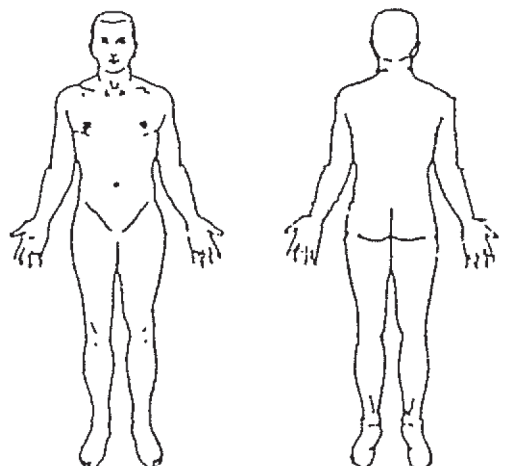
SUMMARY OF OCCUPATIONAL HISTORY (To Be Supplied By Physician)

Date	Signature of Physician
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Physical Examination — Page 5 of 5

Name _____	SEX M F	Date of Birth _____	Marital Status: S M W D Sep
Last First Middle			
Home Address _____	Street	City	State Zip Code
Company _____	Job Title/Division _____	S.S.# _____	
		Phone _____	

Height	Weight	Blood Pressure Sys/Dias	Rechecks
Temperature	Pulse	Resp Rate	
X-Ray <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Vision	Normal Abn
Urinalysis Alb _____ Sugar _____ Bld _____ pH _____ S.G. _____		Far <input type="checkbox"/> Uncorrected R20 L20 <input type="checkbox"/> Corrected	DEPTH <input type="checkbox"/> <input type="checkbox"/>
Audiometric <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Near <input type="checkbox"/> Uncorrected R20 L20 <input type="checkbox"/> Corrected	COLOR <input type="checkbox"/> <input type="checkbox"/>
Electrocardiogram <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Allergies	PERIPHERAL <input type="checkbox"/> <input type="checkbox"/>
Spirometry <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Medications	
		Last Tetanus	

	Normal	Abnormal	Not Done	
1. APPEARANCE				<p>DESCRIBE ABNORMALITIES</p> <div style="text-align: center; margin-top: 50px;">  </div>
2. EYES				
3. EARS				
4. NOSE				
5. MOUTH				
6. TEETH & GUMS				
7. PHARYNX				
8. NECK & THYROID				
9. BREASTS				
10. THORAX				
11. LUNGS				
12. HEART				
13. ABDOMEN				
14. INGUINAL REGION				
15. ANUS & RECTUM				
16. GENITO-URINARY				
17. MUSCULO-SKELETAL				
18. EXTREMITIES				
19. SKIN				
20. LYMPH NODES				
21. NEUROLOGICAL				
22. MENTAL ATTITUDE				

FOR PREPLACEMENT EXAMINATIONS ONLY:

- MEDICALLY ABLE TO PERFORM WITHOUT RESTRICTIONS
- MEDICALLY ABLE TO PERFORM WITH THE FOLLOWING RESTRICTIONS:

- NOT MEDICALLY ABLE TO PERFORM ESSENTIAL FUNCTIONS OF THE JOB

Comments: _____

Physician Signature _____ Date _____