TriHealth

Occupational Medicine Services

SCHOOL BUS DRIVER MEDICAL HISTORY

Name:	Sex M F	Date of Birth	Social Security Number

Have you had or do you now have any of the following conditions? Check (✓) 'Yes' or 'No.' Indicate age when condition occurred.

	Yes	No	Age		Yes	No	Age		Yes	No	Age
Allergies, hay fever, drug reaction				Epilepsy or seizures				Other autoimmune disorder(s)			
Ankle weakness				Eye trouble, injury, blindness				Paralysis			
Asthma				Fibromyalgia				Polio			
Anemia or blood disease				Foot trouble				Rectal disease, blood in stool, hemorrhoids			
Back trouble				Headaches, frequent or severe				Rheumatic fever			
Bone or joint deformity				Hearing loss				Rheumatism or arthritis			
Bowel trouble				Heart trouble				Sexually transmitted diseases (STD)			
Broken bone(s)				Hepatitis or liver disease				Shoulder, painful or "trick"			
Cancer or tumor				Hernia				Sinus trouble			
Chest pain or pressure				High blood pressure				Skin disease			
Chronic cough				Hives				Thyroid trouble			
Compromised immune system				Kidney stone or blood in urine				Tuberculosis			
Diabetes				Knee, painful, "trick" or "locked"				Ulcers			
Dizziness/fainting spells, head injury or loss of consciousness				Memory loss				Varicose veins			
Elbow, painful or "trick"				Nervous breakdown				Other			

Yes	No	HISTORY
❒	❒	Have you ever been hospitalized? Date(s): Reason:
❒	❒	Have you ever had surgery? Date(s): Type of surgery:
❒	❒	Have you had any major illnesses in the past five (5) years? Date(s): Condition:
❒	❒	Are you currently being treated for a medical condition? Condition:
❒	❒	Are you currently taking any medications either prescribed or over the counter (include birth control pills or herbs)? List medication(s):

Yes	No	PERSONAL HABITS
❒	❒	Do you now or have you ever smoked or used tobacco products? Type: Amount per day: # of years: Quit (date):
❒	❒	Do you presently consume alcoholic beverages? Type: # Days per week Amount per day:
❒	❒	Do you exercise regularly? Type: # Days per week:

Patient Signature: _____ Date: _____