MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency Is the Office of The Surgeon General.

REPORT TITLE :

Periodic Occupational Medical History Questionnaire

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

Name (Last, First, Middle):	Last 4 of Social Security Number:	Date of Birth:
Job Location:	Job Title/Position:	Telephone Number:
I certify that the following information is true to the best of my knowledge. Signature: Date:		Email:

Please answer the following questions regarding your medical history and health habits. This information will be used to make a medical assessment of whether you can safely and effectively perform the duties of your current job, and will be handled in a confidential manner. Providing false or incomplete responses could result in loss of compensation or employment.

SINCE YOUR LAST OCCUPATIONAL EXAMINATION, HAVE YOU:

	Yes	No
1. Had a change in your health?		
2. Been admitted to a hospital?		
3. Had any surgical procedures?		
4. Started any new medication?		
5. Had difficulty performing any work activity?		
6. Had any work-related injuries or illnesses?		
7. Had any injuries or illnesses that affect your work?		
8. Had any work or activity restrictions?		
9. Filed a Workers' Compensation claim?		
10. Been out of work for any medical reason?		
11. Had any hazardous exposures at work?		
12. Had concerns about the safety of your workplace?		

Explain All YES Answers. List number of question and explain (example: 7. Low back pain, resolved, no problems.)

AT THIS TIME (CURRENTLY):

	Yes	No
13. Do you have any work or activity restrictions?		
14. Do you have any pain that affects your work?		
15. Are you concerned about your health as it relates to your work?		
16. Are you unable to perform any particular motion or activity?		
17. Do you have a permanent impairment or restrictions?		
18. Is there any part of your job that you can not perform?		
19. Do you have any medical problems that affect your work?		
20. Are you taking any medications?		

List any medication used, including prescription or non-prescription drugs that could affect your ability to safely work, concentrate, or stay awake.