OCCUPATIONAL HEALTH MEDICAL HISTORY FORM

DMA Form 5.3-R (Dec 2017)

PRIVACY ACT STATEMENT - DISCLOSURE OF MEDICAL OR DENTAL INFORMATION: In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please fill out the form completely and accurately. **AUTHORITY:** Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R. **PRINCIPAL PURPOSE(S):** This form will be used exclusively by a medical health professional to evaluate your qualifications for the position within the Wisconsin Department of Military Affairs you are applying for or are currently assigned. **ROUTINE USE(S):** This form was designed to explore those areas which bear directly upon the physical demands of the position for which you have applied or are currently assigned. A thorough and accurate evaluation of this information will contribute to sound employment decisions benefiting both you and the Wisconsin Department of Military Affairs. The information provided will become part of your medical record. **DISCLOSURE:** Voluntary. All statements are subject to verification and deliberate inaccuracies or omissions may bar or remove you from employment.

Last Name, First Name, Middle Name (Suffix)	Date of Birth (mm/dd/yyyy)	Today's Date (mm/dd/yyyy)
Home Address (Street, Apartment No., City, State, and Zip Code)	Home Phone w/Area Code	Work Phone w/Area Code
	Job Title	

Please Complete All Questions. If None, Please Indicate "None" (attach separate sheet if necessary)

Do you feel you have any health problems? If yes, explain:

Are you being treated or followed for a medical condition at this time? If yes, explain:

List **any/all** surgeries and dates:

List other hospitalization (reason and dates):

List **any/all** serious injuries (nature and dates):

List **any/all** serious illnesses and dates:

1. Do you currently use tobacco? YES ☐ NO ☐

If "YES", for how years? _____

Describe use: CHEW: Number of canisters per week: _____

SMOKE: Number of packs per week: _____

Other: _____

2. Do you drink alcoholic beverages? YES ☐ NO ☐

If "YES", number of drinks (wine, beer, liquor) per week: _____

3. How many hours per week do you engage in exercise ***outside of work*** (such as brisk walking, jogging, bike riding). _____

4. When was your last Tetanus shot? Don't Remember: ☐

Date/Year _____ Clinic Location: _____

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained on next page

	YES	NO
5. Are you having trouble keeping up with the physical demands of your current job (such as climbing, lifting, walking, etc.)?	☐	☐
6. Have you had any health problems or injuries that you have experienced related to your present or past job(s), including worker compensation claims?	☐	☐
7. Do you currently have any physical work restrictions?	☐	☐
8. Have you ever been given a disability rating?	☐	☐
9. Do you take any medications regularly?	☐	☐

CONTINUED ON NEXT PAGE

	YES	NO
10. Do you have any allergies (medicines, food, pollen, substances, latex, etc.)?	☐	☐
11. Have you ever had a problem with alcohol or drug abuse?	☐	☐
12. Have you ever had a heat or cold weather related injury/illness?	☐	☐
13. Do you have problems with sleep, excessive stress or feeling tired most of the time?	☐	☐
14. Have you ever had cancer?	☐	☐
15. Do you have any skin problems?	☐	☐
16. Do you have difficulty hearing or with ringing in your ears?	☐	☐
17. Have you ever had asthma, wheezing, persistent cough, shortness of breath, or emphysema?	☐	☐
18. Have you had heart problems, pain or tightness in your chest, arms, neck or jaw?	☐	☐
19. Have you ever had high blood pressure?	☐	☐
20. Have you had stomach problems or ulcers?	☐	☐
21. Have you ever had any liver or kidney problems?	☐	☐
22. Have you ever had a hernia (rupture)?	☐	☐
23a. Have you ever had, or do you currently have, pain in the neck muscles, back muscles or joints?	☐	☐
23b. Is your activity limited because of this pain?	☐	☐
24. Have you ever been diagnosed with Carpal Tunnel, Tendonitis, or Bursitis?	☐	☐
25. Have you ever had numbness, tingling, or weakness of your arms, hands, legs or feet?	☐	☐
26. Have you ever had seizures, convulsions, dizziness, blackouts, or fainting spells?	☐	☐
27. Have you been treated for anxiety, depression or other mood disorders?	☐	☐

Please fully explain all "YES" answers by indicating question number and explanation.

TO BE READ AND SIGNED BY PATIENT: I hereby certify that the information given by me on this form is true and correct.

Patient's Signature: _____ Date: _____

Medical Provider Information

Member IS / IS NOT medically cleared for participation in the Physical Readiness Test.

If not cleared, reason and expected date for clearance:

_____

_____

_____

_____

_____

_____

_____

_____

Expected Date for Clearance

Medical Provider Name - PRINT

Medical Provider SIGNATURE

Facility

Please mail originals and fax this completed form, along with lab and other documentation, to the following address and mark as "CONFIDENTIAL":

Department of Military Affairs
State Human Resources
ATTN: Risk Management Officer
PO Box 14587
Madison, WI 53708-0587
Confidential FAX: (608) 242-3168