OCCUPATIONAL HISTORY THE WORK CLINIC

1. Please fill out following information:

Patient Name		**Today's Date**	
Patient Job Title		**Date of Hire**	
Employer Name		**Date of Injury**	
Employer Address		**Claim Number**	
		Supervisor Name	
Type of Industry		**Supervisor Number**	
Employment Status	☐ Full-time ☐ Part-time	**Supervisor Job Title**	

- Do you undergo any routine medical tests related to work? ☐ Yes ☐ No
  If yes which one(s) and why? (silica, lead, isocyanates, asbestos, other)
  ☐ Hearing tests ☐ Chest x-rays ☐ Pulmonary function tests
  ☐ Bloods tests ☐ Other (please list): _____

- Do you wear Personal Protective Equipment? ☐ Yes ☐ No
  If yes, which one(s):
  ☐ Gloves ☐ Coveralls ☐Safety glasses ☐Hearing protection
  ☐ Mask ☐ Respirator ☐Safety shoes ☐Other (please list): _____

2. List past jobs and include short-term, seasonal, and part-time employment. Add complete job duties (welding, painting, etc)

Dates of Employment	Employer Name	Job Title	Job Duties