

Research Donor Program Medical Health History

NCI-Frederick's Occupational Health Services (OHS) respects the privacy rights of all active and perspective employees. Disclosure of any/all personal medical information is voluntary. OHS handles all medical information in the strictest confidence. OHS requests that you complete the following:

Name Last	First	Middle	RDP#(OHS Only)	
Home Telephone (Include Area Code)	Work Telephone (Include Area Code)	Bldg/Room	Supervisor's Name	
Race <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Cell Phone (Include Area Code)	Date of Birth (Mo/Day/Yr)	Person to Notify in Case of Emergency		
Emergency Contact Telephone (Include Area Code)				
H.			C.	

Personal Health History

1. Medications, Drugs, Vitamins, Herbs, or Over the Counter Medications taken in the last two weeks or regularly.

2. When have you received the following immunizations?

Tetanus/Tdap _____	Yellow Fever _____
Varicella _____	Influenza _____
Hepatitis B _____	Typhoid _____
Vaccinia _____	MMR _____
Hepatitis A _____	

Past Medical History

1. Indicate if you have ever had any of the following medical Conditions (Check if Yes & Circle)

<input type="checkbox"/> Traveled outside of the USA	<input type="checkbox"/> Varicose Veins/Phlebitis	<input type="checkbox"/> Received Blood Transfusion
<input type="checkbox"/> Anemia/Bleeding Disorders/ Blood Diseases	<input type="checkbox"/> Irregular Pulse	<input type="checkbox"/> Blood Thinners
<input type="checkbox"/> High Blood Pressure/ Heart Disease	<input type="checkbox"/> Persistent Nausea/ Vomiting	<input type="checkbox"/> Stroke/Paralysis
<input type="checkbox"/> Heart Attack/Angina	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Heart Failure/Swelling In Feet/Legs	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Restriction Due to Heart Problems	<input type="checkbox"/> Cancer/Tumor/Leukemia
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Recent Surgery Type: _____	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cardiac Surgery	<input type="checkbox"/> Allergy that interferes with Breathing	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Diabetes/Sugar Disorders	<input type="checkbox"/> Skin Allergy or Sensitivity	<input type="checkbox"/> Bruising Easily
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Latex Allergy or Sensitivity	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Received Blood Transfusion	<input type="checkbox"/> Allergy to Medications, list: _____	<input type="checkbox"/> History of DVT
<input type="checkbox"/> Loss of Consciousness/ Seizures/Convulsions	<input type="checkbox"/> Cardiac Stents	<input type="checkbox"/> Malaria
<input type="checkbox"/> Breathing Difficulties/ Chronic Cough		

2. During the past year, have you had any of the following symptoms?

Chest Pain/Angina

Unsteadiness in Balance/
Dizzy Spells

Problems with Nervousness

A Seizure or Convulsion

A Tremor

Easy Bruising/Bleeding

Shortness of Breath-At Rest

Shortness of Breath-Exertion

Wheezing in the Chest

Persistent Hoarseness

Persistent/Unusual Cough

Blood Transfusion

Chest Pain/Tightness or Discomfort

Heart Palpitations or Skipped Beats

Drug Use/ Overdose

Muscle Weakness

Excessive Fatigue

Unusual Bleeding/DVT

Pulmonary Embolism

Social History

Tattoo Date: _____

Piercing Date: _____

Alcohol

Smoking History

Currently a smoker?
 (or Chewing Tobacco)

E-Cigarettes

Have you ever regularly smoked Cigarettes? Start Age _____
Number of Cigarettes(etc) smoked daily _____

Women Only

Hormone Treatments

Currently Pregnant

Birth Control Pill

Breast Feeding

HPV Vaccine

Other

I faint when I get a Venipuncture

I Weight less than 110 Pounds

Patient Signature: _____ Initials of Reviewer: _____