



- ProHealth - John Street
- ProHealth - Elm Valley Dr.
- ProHealth - Paw Paw
- ProHealth - Battle Creek

Affix Patient Label

1. Name: _____ 2. Social Security #: _____
3. Present Occupation/Job Title: _____ 4. Company: _____
5. Address: _____ (Zip Code) _____
6. Telephone Number: _____
7. Date: _____ 8. Date of Birth: _____

OCCUPATIONAL HISTORY

9. A. In the past year, did you work full time (30 hours per week or more) for 6 months or more? Yes No
 If "YES" to 9A:
- B. In the past year, did you work in a dusty job? Yes No Does Not Apply
 Was dust exposure: Mild Moderate Severe
- C. In the past year, were you exposed to gas or chemical fumes in your work? Yes No
 Was exposure: Mild Moderate Severe
- D. In the past year, what was your: Job occupation _____ Position/job title: _____

RECENT MEDICAL HISTORY

10. Do you consider yourself to be in good health? Yes No
 If "NO", state reason _____
11. In the past year, have you developed:
- | | Yes | No | | Yes | No |
|-----------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|
| Epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> | Bladder disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice? | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

CHEST COLDS & CHEST ILLNESS

12. If you get a cold, does it usually go to your chest? (usually means more than 1/2 the time)
 Yes No Don't get colds
13. A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes No Does not Apply
 If "YES" to 13:
- B. Did you produce phlegm with any of these chest illnesses? Yes No Does Not Apply
14. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more?
 No such illnesses Number of illnesses _____

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RESPIRATORY SYSTEM

15.	In the past year have you had:	Yes	No	Further Comment on Positive Answers
	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Chest Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Other Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
16.	Do you have:	Yes	No	Further Comment on Positive Answers
	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Shortness of breath when walking or climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
17.	Do you:			
	Wheeze	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Cough up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Smoke cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day _____ How many years _____

Signature _____ Date _____

Reviewed by: _____ Date: _____ Time: _____