# Occupational Health Screening Form

## Section 1: Employee Information

Full Name: _____

Employee ID: _____

Date of Birth: _____

Job Title: _____

Department: _____

Contact Number: _____

Email: _____

Section 2: Medical History

1. Do you have any pre-existing medical conditions? (e.g., asthma, diabetes, heart disease)
   - [ ] Yes - [ ] No
   - If Yes, please specify: _____
2. Have you had any serious illnesses or hospitalizations in the last 5 years?
   - [ ] Yes - [ ] No
   - If Yes, please provide details: _____
3. Do you have any allergies (medications, food, environmental)?
   - [ ] Yes - [ ] No
   - If Yes, list allergens: _____
4. Are you currently taking any medications?
   - [ ] Yes - [ ] No
   - If Yes, please list: _____
5. Have you ever experienced any work-related illnesses or injuries?
   - [ ] Yes - [ ] No
   - If Yes, describe: _____

Section 3: Occupational Exposure

6. Have you been exposed to any of the following in your job? (Check all that apply)
   - [ ] Noise - [ ] Chemicals - [ ] Dust/Fumes - [ ] Radiation
   - [ ] Extreme Temperatures - [ ] Heavy Lifting - [ ] Infectious Materials
   - [ ] Others (please specify): _____

7. Do you use personal protective equipment (PPE) regularly at work?

- [ ] Yes - [ ] No
- If Yes, specify the type of PPE used: _____

Section 4: Physical and Mental Health Assessment

8. Do you experience any of the following symptoms? (Check all that apply)

- [ ] Frequent headaches - [ ] Shortness of breath - [ ] Dizziness or fainting
- [ ] Chronic pain - [ ] Stress or anxiety - [ ] Depression
- [ ] Vision or hearing issues - [ ] Other (please specify): _____

Section 5: Health and Wellness Assessment

9. How often do you exercise?

- [ ] Never - [ ] Occasionally - [ ] Regularly

10. Do you smoke or use tobacco products?

- [ ] Yes - [ ] No

11. Do you consume alcohol?

- [ ] Never - [ ] Occasionally - [ ] Regularly

12. Do you follow a balanced diet?

- [ ] Yes - [ ] No

Section 6: Declaration & Signature

I confirm that the information provided above is accurate to the best of my knowledge.

I understand that this form is used for occupational health assessment purposes and may be reviewed by authorized personnel.

Signature: _____

Date: _____