<table>
<thead>
<tr>
<th>Current Medications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Allergies:</td>
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<tr>
<td>Latex Allergies:</td>
</tr>
<tr>
<td>Drug Allergies:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other - Please specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumps</td>
</tr>
<tr>
<td>Rash</td>
</tr>
<tr>
<td>Non-healing sores</td>
</tr>
<tr>
<td>Change in lesions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
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</thead>
<tbody>
<tr>
<td>Fribrosis change</td>
</tr>
<tr>
<td>Pain</td>
</tr>
<tr>
<td>Masis/lump</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lomma</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Past Present</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endocrine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musclekeletal</td>
</tr>
</tbody>
</table>

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平衡
Dizziness/Loss of orientation
Numbness/Lightning
Imbalance
Difficulty Speaking
Convulsion/seizures
Neurological

上肢/下肢疼痛
Numbness/Lightning
Radiating pain
Back or neck pain
Limited motion
Muscle pain
Joint swelling
Joint pain
SOCIAL HISTORY:

If yes, specify anesthetic and type of reaction:

Have you ever had an anesthetic reaction?

No [ ] Yes [ ]

HOSPITALIZATION OR SURGERY (Include dates):

[ ] Cardiac
[ ] Cancer
[ ] BronchiH
[ ] Breast Lumps
[ ] Bleeding Disorders
[ ] Allergy/Wheezing
[ ] Arthritis
[ ] Anemia
[ ] AIDS/HIV

PAST MEDICAL HISTORY: Check (v) conditions you have or have had in the past.
If deceased, list cause of death and age at death

Other:

---

1. Type(s):
   - [ ] Cancer
   - [ ] Stroke
   - [ ] Heart Disease
   - [ ] Pulmonary Embolism
   - [ ] COPD (Chronic Obstructive Pulmonary Disease)
   - [ ] Asthma
   - [ ] Kidney Disease
   - [ ] Thyroid Disease
   - [ ] Diabetes

Family Member: Yes, No

---

Other Family Health Problems (check boxes below)

- [ ] If alive, present age(s):
  - [ ] Father:
  - [ ] Mother:
  - [ ] Child(ren):
  - [ ] Sister(s):
  - [ ] Brother(s):

---

Family History:
Have you or your partner ever conceived a child resulting in a miscarriage, stillbirth, or death?

If Yes: Please state the diagnosis that was made: □ partner □ self □ partner and self □ partner and previous partner

Have you or your partner consulted a physician for a fertility or other reproductive problem?

If Yes: Please specify who consulted the physician: □ partner □ self □ partner and self

REPRODUCTIVE HISTORY:

Last training date:

Personal protection equipment used:

Duration (minutes/hours/handling each):

Frequency (circle one - day or week):

Most commonly handled drugs/chemicals:

EXPOSURE HISTORY:
What was the date this abnormality or irregularity stopped?

If yes, when was the date this abnormality or irregularity began?

If yes, please specify the type of abnormality or irregularity:

9. Have you ever had any menstrual abnormality or irregularity?

For females:

8. What is the occupation of your spouse or partner?

Did the timing of any abnormal pregnancy coincide with your present employment?

If yes, to question 3, was this outcome a result of a pregnancy with your present partner or previous partner?

If the outcome was a deformity, please specify or describe the type:

If yes to question 3, please specify the type of outcome: miscarriage, stillbirth, deformed, others...
10. Have you ever had an abnormal pap?

Yes □

No □

11. Have you been diagnosed with endometriosis?

Yes □

No □

12. Number of pregnancies:

Number of miscarriages:

Because of fetal abnormality

Premature or terminated early