Occupational History

1. Starting with your *current* Employer, please list job titles you have held in the table below. Also, list separately each different job title within a company (transferred or promoted).

Employer/Company	Job Title/Position	From (month/year)	To (month/year)	Brief Description

2. Do you work for more than one Employer? □ No □ Yes

3. Do you operate a business of your own? □ No □ Yes

4. Have you served in the military? □ No □ Yes
If yes, in what branch did you serve? _____
What years did you serve? _____
Were you discharged with any injury disability ratings? □ No □ Yes_____

5. Have you filed Workers' Compensation Claims previously? If yes, please note them below, starting with the most recent and working back.

Employer/Company	Year	Body Part/Diagnosis	Final Disability Rating?

6. Do you need any special accommodations with your job? □ No □ Yes
If yes, please describe any *permanent work restrictions* or special *accommodations* you need:

_____

7. Have you ever needed to wear Personal Protective Equipment (PPE) for this or previous jobs? Please *circle* those that you recall using:
Respirator (Type(s): _____)
Ear Plugs or Muffs *Gloves* Safety glasses *Safety goggles* Hood *Tinted Visor*
Protective Clothing / Gown / Suit *Steel-Toed Boots* Dust Mask
Chain mail Gloves *Lead Apron* Bullet-Proof Vest *Dive Suit*

Did you have difficulty wearing any of this PPE? □ No □ Yes
If yes, please describe the problem:
_____

8. Have you ever had any work-related exposures (chemical, physical, biological, radiation) when not protected by PPE?
□ No
□ Yes If yes, please describe the exposure using the table below.

Year	Exposure Type	Medical Evaluation?	Current Status

9. Please *check* those items that you would routinely need to use in the workplace.
□ Contacts □ Glasses □ Hearing Aid(s) □ Pacemaker
□ Braces or supportive devices □ Wheelchair □ Other: _____