Occupational Health Clinical Center (OHCC)

UPSTATE
MEDICAL UNIVERSITY

Serving Workers with Occupational Illness, Injury or Disease in the Central New York Region

PATIENT INFORMATION

ORGANIZATION: ______________________________ DATE OF VISIT: ______________

______________________________ DATE OF BIRTH: ______________
(FIRST NAME) (MI) (LAST NAME)

____
(ADDRESS)

____
(CITY) (STATE) (ZIP) (COUNTY)

AGE________ SEX ☐ M ☐ F ETHNICITY ☐ WHITE ☐ BLACK ☐ HISPANIC ☐ ASIAN ☐ NATIVE AMERICAN

PHONE HOME (_____)______________CELL (_____)_____________CURRENT WORK (____)____________

SS #:____________________ MARITAL STATUS__________ COUNTRY OF BIRTH________________

NAME & PHONE NUMBER OF YOUR PERSONAL PHYSICIAN______________________________

IN CASE OF EMERGENCY NOTIFY:______________________________ PHONE______________

ARE YOU A MEMBER OF A UNION? ☐ YES ☐ NO UNION AND LOCAL #: ______________________

HOW MUCH SCHOOLING DID YOU COMPLETE? (LAST LEVEL COMPLETED 1-17+)__________________

ARE YOU ALLERGIC TO LATEX? ________NO__________

IF NEW YORK STATE DEPARTMENT OF HEALTH WISHES TO CONDUCT FURTHER STUDIES, WOULD YOU BE WILLING TO BE CONTACTED FOR POSSIBLE PARTICIPATION? ☐ YES ☐ NO

LIST ALLERGIES TO MEDICATIONS:______________________________

____

FOR LEAD SCREENING, ARE THERE CHILDREN LIVING IN YOUR HOUSEHOLD? ☐YES ☐NO AGES:__________

HAVE YOU EVER SMOKED? ? ☐YES ☐NO DO YOU CURRENTLY SMOKE? ☐YES ☐NO

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