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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