ROCC
REGIONAL OCCUPATIONAL CARE CENTER
A UNITY HEALTHCARE PARTNER

Date: _____

Name (last): _____ (first): _____ (middle initial): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Social Security #: _____ Race: _____ Sex: Female □ Male □

In case of emergency, notify:
Name: _____ Relationship: _____

Address: _____ Phone: _____

INDUSTRIAL HISTORY

Have you ever worked:	If yes, how many years?
1. as a miner (ie: coal, iron, etc.)	YES □ NO □ _____
2. in a foundry	YES □ NO □ _____
3. as a sandblaster	YES □ NO □ _____
4. as a chipper	YES □ NO □ _____
5. as a grinder	YES □ NO □ _____
6. as a welder	YES □ NO □ _____
7. with asbestos / silicone	YES □ NO □ _____
8. with poisonous material	YES □ NO □ _____
9. with radioactive substances	YES □ NO □ _____
10. at a job requiring repetitive motion	YES □ NO □ _____

Have you ever been sensitive to sunlight, chemicals, dust, or other material?
YES □ NO □ If yes, explain: _____
_____

Have you ever required a special job assignment for health reasons?
YES □ NO □ If yes, explain: _____
_____

List any hobbies/activities you are involved in (ie: models, carpentry, piano, etc.)
_____

MILITARY HISTORY

Have you ever been in the Uniformed Services?: YES □ NO □ If yes, which branch?: _____
Years of service?: _____ Military job?: _____
Assignment locations?: _____

PAST MEDICAL HISTORY

How would you describe your current health? _____

Scarlet Fever	YES □ NO □	Dizziness	YES □ NO □	Arthritis	YES □ NO □
Heart Trouble	YES □ NO □	Stomach Ulcers	YES □ NO □	Emphysema	YES □ NO □
Tuberculosis	YES □ NO □	Vomiting Blood	YES □ NO □	Concussion	YES □ NO □
High Blood Pressure	YES □ NO □	Fainting	YES □ NO □	Convulsions	YES □ NO □
Kidney Disease	YES □ NO □	Back Trouble	YES □ NO □	Glaucoma	YES □ NO □
Hepatitis	YES □ NO □	Cancer	YES □ NO □	Deafness	YES □ NO □
Head or Neck Injury	YES □ NO □	Rheumatic Fever	YES □ NO □	Sciatica	YES □ NO □
Anemia	YES □ NO □	Pneumonia	YES □ NO □	Chronic Diarrhea	YES □ NO □
Hemophilia	YES □ NO □	Asthma	YES □ NO □	Thyroid Problems	YES □ NO □
Nervous Breakdown	YES □ NO □	Cataracts	YES □ NO □	Skin Trouble	YES □ NO □
Shortness of Breath	YES □ NO □	Diabetes	YES □ NO □	Broken Bones	YES □ NO □
Chronic Headaches	YES □ NO □	Jaundice	YES □ NO □		

(continued on back side)

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Any other significant illness or injury?: YES □ NO □ If yes, explain: _____

Have you ever had any operations?: YES □ NO □ If yes, explain: _____

Have you ever been hospitalized?: YES □ NO □ If yes, explain: _____

	YES	NO		YES	NO
Do you wear glasses?			Have you ever been a smoker?		
Do you wear contacts?			What age were you when you started? _____		
How long? _____ years			If you are no longer a smoker, at what age did you stop? _____		
Do you wear hearing aids?			What did you smoke? Cigarettes □ Pipe □ Cigars □		
			How much did / do you smoke? _____ packs per day		

Have you ever collected workman's compensation?: YES □ NO □ If yes, explain: _____

Do you have any physical limitations or disabilities?: YES □ NO □ If yes, explain: _____

Are you presently taking any medications?: YES □ NO □ If yes, explain: _____

List any **allergies** to medications or other substances: _____

I CERTIFY THAT I HAVE ANSWERED THE PRECEDING QUESTIONS TRUTHFULLY TO THE BEST OF MY ABILITY.

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical / surgical care, tests, procedures, drugs, and other services and supplies as my physician, in his / her professional judgement deems necessary or beneficial. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I was offered a copy of the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the practice as described in the notice.

DATE: _____ SIGNATURE: _____

DATE: _____ PROVIDER SIGNATURE: _____