UF Environmental Health and Safety
UNIVERSITY of FLORIDA

ANNUAL MEDICAL HISTORY QUESTIONNAIRE FOR THE PESTICIDE PROGRAM

Occupational Medicine Program

Name:	**UFID #:**	**Date of Birth:**
Height:	**Weight:**	**Age:**

Position (Title):	**LP#:**
Supervisor:	**Department:**
Address:	**Work Telephone Number:**

Do have any exposure to anti-cholinesterase type pesticides (if Yes please describe):

Have you had or do you now have any of the following:	**Yes**	**Within the Last Year?**	**No**
1. Lung disease			
2. Persistent cough			
3. Shortness of breath			
4. History of fainting or seizures			
5. Heart Trouble			
6. Frequent pain / tightness in chest			
7. Heartburn/indigestion not related to eating			
8. High blood pressure			
9. Diabetes			
10. Trouble concentrating or remembering			
11. Heat exhaustion or heat stroke			
12. Ruptured ear drum			
13. Defective vision			
14. Defective hearing			
15. Other conditions that might interferewith respirator use or result in limited work ability			
16. Are you taking any medications (prescription or over-the-counter) If Yes, LIST:			
17. Do you currently smoke? If Yes, how many do you smoke per day?			
18. Have you had a significant medical or surgical problem since your last evaluation?			

Please Explain Yes Answers:

Employee's Signature:	Date:

Physician Use Only

❑ **No Restriction on Pesticide Use**	❑ **Further Evaluation Needed**
Physician's Review Signature:	**Date:**