2741 Debarr, Rd, Tower C, Ste 311
Anchorage, AK 99508
P: 907-777-1877
F: 855-468-1357

ARETE OCCUPATIONAL HEALTH

Hours of Operations
Monday-Friday
8:00 AM-5:00 PM

Occhealth@afcak.com

Name (First, Middle, Last)	Date of Birth	Age	Sex
Employer	Position		

Reason for Physical Assessment ☐ Post Offer ☐ Post Accident ☐ Return to work

Personal History

Please answer the following questions	Yes	No	Comments
Do you wear contacts or glasses?	☐	☐	Last optometrist appt:
Have you ever had surgery?	☐	☐	
Do you anticipate any surgery?	☐	☐	
Do you anticipate any medical treatment?	☐	☐	
Have you ever had an EKG?	☐	☐	
Are you up to date on your vaccinations?	☐	☐	Last tetanus:
Do you have any allergies?	☐	☐	☐ Anaphylaxis ☐ Environmental ☐ Hives
Have you ever had a Chest X-ray?	☐	☐	
Do you exercise outside of work?	☐	☐	Hours/week
Do you smoke or chew tobacco?	☐	☐	How many years: packs per day:
Former smoker?	☐	☐	How many years: packs per day:
Do you consume alcohol	☐	☐	Drinks per week:

Medical History

Please list any of the following that has been diagnosed by a Healthcare Provider.

Cancers & Blood	Yes	No	Gastrointestinal cont.	Yes	No	Musculoskeletal cont.	Yes	No
1. Anemia	☐	☐	20. Bowel Disease	☐	☐	38. Head Injury	☐	☐
2. Blood clots	☐	☐	21. Ulcers	☐	☐	39. Dislocations	☐	☐
3. Cancer	☐	☐	22. Abdominal Pain	☐	☐	40. Joint Pain	☐	☐
Endocrine	**Yes**	**No**	**Kidney**	**Yes**	**No**	41. Wrist Pain	☐	☐
4. Diabetes	☐	☐	23. Kidney Stones	☐	☐	42. Elbow Pain/Injury	☐	☐
5. Osteoporosis/Osteopenia	☐	☐	24. Kidney Removed	☐	☐	43.Numbness in hands/Feet	☐	☐
7. Thyroid Disorder	☐	☐	**Lung & Respiratory**	**Yes**	**No**	44. Shoulder Pain/Injury	☐	☐
Heart & Vascular	**Yes**	**No**	25. Asthma	☐	☐	45. Tendonitis	☐	☐
8. Heart Murmur	☐	☐	26. Sleep Apnea	☐	☐	46. Carpal Tunnel	☐	☐
9. Angina (Chest Pain)	☐	☐	27. COPD	☐	☐	47. Arthritis	☐	☐
10. Atrial Fibrillation	☐	☐	28. Chronic Bronchitis	☐	☐	48. Knee Injury	☐	☐
11. Heart Failure	☐	☐	**Neurological**	**Yes**	**No**	49. Ankle Pain/Injury	☐	☐
12. Heart Attack	☐	☐	29. Seizures or Epilepsy	☐	☐	50. Fractures	☐	☐
13. Irregular Heartbeat	☐	☐	30. Stroke	☐	☐	51. Gout	☐	☐
14. High Blood Pressure	☐	☐	31. Migraine	☐	☐	52. Major Surgery/Repair	☐	☐
Eye, Ear nose, throat	**Yes**	**No**	**Skin**	**Yes**	**No**	53. Hip Injury	☐	☐
15. Color Blind	☐	☐	32. Acne	☐	☐	54. Muscle Repair	☐	☐
16. Hearing Loss	☐	☐	33. Eczema	☐	☐	55. Other	☐	☐
17. Ear Disorder/injury	☐	☐	34. Skin Cancer	☐	☐	**Mental Health**	**Yes**	**No**
Gastrointestinal	**Yes**	**No**	**Musculoskeletal**	**Yes**	**No**	56. Anxiety	☐	☐
18. Hepatitis	☐	☐	35. Neck Pain / Injury	☐	☐	57. Depression	☐	☐
19. Gallbladder Stones	☐	☐	36. Back Pain / Injury	☐	☐	58. Insomnia	☐	☐

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Please list below the corresponding number with condition for any **"Yes"** Anwers on questionnaire on previous page, elaborate on answer, estimated year of diagnosis, treatment needed, etc.

Number	**Medical condition**

List all over the counter and prescribed medication:

Medication Name	Dosage	Frequency

Patient signature_____ Date_____

Phone Number: _____

Emergency contact name: _____

Emergency contact phone number: _____