

HISTORY QUESTIONNAIRE

MEDICAL DEPARTMENT
OM-760

B.F. GOODRICH CHEMICAL COMPANY

DATE 5/15/68		LOCATION B.F. GOODRICH CHEM. CO		FILE NO.
NAME [REDACTED]		NAME OF NEAREST LIVING RELATIVE [REDACTED]		
ADDRESS [REDACTED]		ADDRESS [REDACTED]		
HOME PHONE [REDACTED]	DATE OF BIRTH [REDACTED]		FAMILY PHYSICIAN [REDACTED]	
☐ SINGLE	☐ SEPARATED	☒ MALE		ADDRESS [REDACTED]
☒ MARRIED	☐ DIVORCED	☐ FEMALE		
☐ WIDOWED				

FAMILY HISTORY

RELATIONSHIP	LIVING		AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	CONDITION OF HEALTH (IF ANSWERED OTHER THAN "GOOD" GIVE DETAILS)
	YES	NO				
FATHER		X		72	STROKE	
MOTHER		X		62	"	
BROTHERS	X		57			Good
	X		64			"
SISTERS	X		52			"
	X		55			"
	X		65			"

PAST MEDICAL HISTORY

Have you ever had or been treated for:

	YES	NO		YES	NO		YES	NO
ALLERGY		✓	MUMPS		✓	JAUNDICE		✓
ASTHMA, HAY FEVER		✓	RUPTURE		✓	KIDNEY STONES		✓
SKIN RASH	✓		SCIATICA		✓	BACK INJURY		✓
ARTHRITIS		✓	STOMACH ULCERS		✓	UNCONSCIOUSNESS		✓
OTITIS	✓		TROPICAL DISEASES		✓			
RHEUMATIC FEVER		✓	TUBERCULOSIS		✓	Have you ever:		
FOOT TROUBLE		✓	TYPHOID FEVER		✓		YES	NO
COLD IN THE BACK		✓	CHEST PAIN		✓	Been in auto accidents		✓
TRICK KNEES		✓	FREQUENT COUGH		✓	Been treated for nervous or mental disease		✓
ANEMIA		✓	SHORTNESS OF BREATH		✓	Received compensation for an industrial injury		✓
CANCER		✓	SPITTING OF BLOOD		✓	Had to change jobs for health reasons		✓
DIABETES		✓	PNEUMONIA		✓	Been refused life insurance		✓
EPILEPSY		✓	HEART TROUBLE		✓			
MENINGITIS		✓	HIGH BLOOD PRESSURE		✓			
MEASLES		✓	GALL BLADDER TROUBLE		✓			

MENTION ANY OTHER DISEASES OR INJURIES YOU HAVE HAD

DIAGNOSED BY DR S. LATONA — RAYNAUDS PHENOMENA

OPERATIONS AND INJURIES	DATE	TREATED BY	ADDRESS

CONDITIONS REQUIRING MEDICAL ATTENTION IN PAST TWO YEARS

MILITARY SERVICE	BRANCH OF SERVICE	LENGTH OF SERVICE	RANK ON DISCHARGE	PERCENT DISABILITY

BFG65252

OVER-

SOCIAL HISTORY

EDUCATION	HIGH SCHOOL	LOCATION <i>TROTT VOCATIONAL</i>	YEARS COMPLETED <i>14</i>	DATE GRADUATED <i>1937</i>
	COLLEGE	NAME	LOCATION	YRS COMPLETED
				DATE GRADUATED
				DEGREES

HOBBIES

FISHING

USE OF ALCOHOLIC BEVERAGES

VERY LITTLE

USE OF TOBACCO (Kind and amount)

NONE (QUIT SMOKING)

USE OF MEDICINES (Kind and amount)

NONE

HOW MANY CHILDREN DO YOU HAVE

THREE

PRESENT HEALTH STATUS

Have you had any of the following conditions in the past year or do you have any of them now?	(DATE OF HISTORY TO BE INSERTED)									
			11/13/70							
	YES	NO	YES	NO	YES	NO	YES	NO	Y'S	NO
WEIGHT CHANGE IN THE LAST YEAR										
BREAKING OUT OR RASH OF SKIN	✓			✓						
WEAKNESS, CHILLS OR FEVER	✓			✓						
HEADACHES	✓			✓						
NERVOUSNESS OR INSOMNIA	✓			✓						
SWELLING OF HANDS OR FEET				✓						
PAINFUL JOINTS	✓			✓						
NOSE BLEEDING, DIFFICULTY BREATHING THROUGH NOSE				✓						
SORE OR BLEEDING GUMS, ULCER IN THE MOUTH				✓						
HOARSENESS	✓			✓						
DIFFICULTY SWALLOWING FOOD OR LIQUIDS				✓						
CHEST PAIN, ESPECIALLY WITH WALKING	✓			✓						
COUGH, DRY OR WITH SPUTUM				✓						
RAPID OR IRREGULAR BEATING OF THE HEART				✓						
SHORTNESS OF BREATH				✓						
LOSS OF APPETITE				✓						
HEARTBURN OR INDIGESTION				✓						
CONSTIPATION, DIARRHEA OR BLOOD IN THE STOOLS				✓						
FREQUENT OR PAINFUL URINATION				✓						
BLEEDING FROM ANY PART OF THE BODY				✓						
MENSTRUAL PAIN OR ABNORMAL PERIODS				✓						
Have you been sick in any significant way since the last examination?				✓						
Have you had occasion to see your physician since last examination?				✓						
ENTER DATE OF LAST MENSTRUAL PERIOD										
HISTORY TAKEN BY										

- ① ② Knee - "achy"
- ② Dr. S. history - for #1
- ③ ① Hand, ② foot "tingle", like cold, - no color change, no pain
- ④ Smoked up to 2 pk up/day - 5 yrs ago - nothing more
- ⑤ faster than ① Hand & foot -

I certify that I have reviewed the information supplied by me and recorded on both sides of this Medical History Questionnaire. To the best of my knowledge it is true, correctly recorded and complete. I authorize any of the physicians, hospitals or clinics mentioned in this questionnaire to supply complete transcript of my medical records to the Medical Department of Olin Mathieson Chemical Corp.

SIGNED

WITNESS

DATE

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