Korean Society of Occupational & Environmental Medicine Special Health Examination Revised Issue

Company:

Name:

※ Questions on Medical History (Patient History, Family History)

※ Please read the following questions and indicate with [**O**] for **current state**.

1. Have you been **diagnosed or are you currently taking medication for any of the following illnesses**?

Illness	Stroke	Heat disease (Myocardial infarction/ Angina pectoris)	High blood pressure	Diabetes	Dyslipidemia	Tuberculosis	Others (including cancer)
Diagnosis							
Medical treatment							

2. Have any of your **parents, brothers, or sisters died from the following illnesses**?

Illness	Stroke	Heat disease (Myocardial infarction/Angina pectoris)	High blood pressure	Diabetes	Others (including cancer)
Yes					

3. Are you a **hepatitis B virus** carrier? ① Yes ② No ③ Don't know

※ Questions on Smoking

Please read the following questions and indicate your **current status**.

4. Have you smoked more than five packs (100 cigarettes) of regular tobacco (cigarettes) over your entire life?

① No (☞ Go to question 5)

② Yes (☞ Go to Question 4-1)

4-1. Do you currently smoke?

① I currently smoke	__ years in total	__ cigarettes a day on average	

② I used to smoke, but I currently do not smoke.	__ years in total	__ cigarettes a day on average, when I used to smoked	I have not been smoking for __ years.

5. Have you ever smoked an electronic cigarette (heat-not-burn tobacco, such as IQOS, glo, or lil)?

① No (☞ Go to question 6) ② Yes (☞ Go to Question 5-1)

5-1. Do you currently smoke a cigarette-type electronic cigarette?

① I currently smoke	__ years in total	__ cigarettes a day on average	
② I used to smoke, but I currently do not smoke.	__ years in total	__ cigarettes a day on average, when I used to smoke	I have not been smoking for __ years.

6. Have you ever used a liquid electronic cigarette?

① No ② Yes (☞ Go to Question 6-1)

6-1. Have you used the liquid electronic cigarette in the past month?

① No ② 1-2 days in a month ③ 3-9 days in a month ④ 10-29 days in a month ⑤ Every day

※ Questions on Alcohol Use (In the Past Year)

Please read the following questions and indicate your **current status**.

7. How often do you drink?

① ( ) times a week ② ( ) times a month

③ ( ) times a year ④ I do not drink

7-1. When you drink, how much do you usually drink?

* Please indicate using one of the units (cups, bottles, cans, or cc). (You can give multiple answers for the types of alcohol but indicate the total amount of alcohol you consumed in a day. For other types of alcohol, indicate it in the slot for a similar type.) *Binge drinking is determined based on the maximum consumption of alcohol in a day.

Type of Alcohol	Cup	Bottle	Can	cc
Soju				
Beer				
Hard Liquor				
Makgeolli				
Wine				

7-2 How much did you drink when you drank the most in a single day?

* Please indicate using one of the units (cups, bottles, cans, or cc). (You can give multiple answers for the types of alcohol but indicate the total amount of alcohol you consumed in a day. For other types of alcohol, indicate it in the slot with a similar type.)

Type of Alcohol	Cup	Bottle	Can	cc
Soju				
Beer				
Hard Liquor				
Makgeolli				
Wine				

※ Questions on Physical Activities (Exercise)

Please read the following questions and indicate your **current status**.

8-1. How many days do you usually engage in high-intensity physical activities that make you short of breath in a typical week?

( ) days per week

(e.g. Running, aerobics, bicycling at high speed, working at a construction site, carrying things upstairs, etc.)

8-2. How many hours in a day do you usually engage in high-intensity physical activities that makes you short of breath?

( ) hours ( ) minutes per day

9-1. How many days do you usually engage in medium-intensity physical activities that makes you slightly short of breath in a typical week?

( ) days per week

(e.g. Power walking, tennis doubles, bicycling at normal speed, carrying light objects, cleaning, etc.)

※ Excluding physical activities related to responses to 8-1 and 8-2

9-2. How many hours in a day do you usually engage in medium-intensity physical activities that makes you slightly short of breath?

( ) hours ( ) minutes per day

10. In the past week, how many days did you engage in muscle training, such as push-ups, sit-ups, dumbbells, barbells, or chin-ups?

( ) days per week

※ Questions about symptoms related to target organs

7. Please respond relating to symptoms experienced in the past six months.

Body Part	Symptoms	Intensity		
		High	Medium	None
General	Lost appetite and weight			
	Feeling of fatigue often			
	Lumps felt in the body			
Skin	Itchy feeling or inflammations			
	Skin rashes			
	Changes to the hair, fingernails, or toenails			
	Skin becomes rough and cracked			
Eyes	Eyes are irritated and tear up more often			
	Eyesight worsening			
	Eyes become bloodshot or hurt			
Ears	Cannot hear clearly			
	Ringing in the ears			
Nose	Frequent nosebleeds			
	Runny or stuffy nose			
	Difficulties smelling			
Mouth	Bloody gums or canker sores			
	Difficulties tasting			
Digestive	I have felt a stinging pain in my stomach.			
	Metallic taste in my mouth			
	Constipation			
Cardiovascular/ Respiratory	Palpitation while working			
	Coughing and shortness of breath while working			
	Chest pressure			
	Coughing or spitting phlegm when waking up			
	Coughing when returning to work after a holiday			

Body Part	Symptoms	Intensity		
		High	Medium	None
Spine/Limbs	Arms, legs, and shoulder aches			
	Trembling or weak hands and feet			
	Hands and feet feeling numb			
	Fingers becoming white when cold			
	Back pain			
Mental/Nervous System	Headaches			
	Dizziness			
	Worsened memory and forgetfulness			
	Anxiety and restlessness			
	Head feels numb or feels as if I am drunk			
	Difficulties concentrating			
Urinary/ Reproductive	Difficulties urinating			
	Body swelling			
	Irregular menstruation			
	Experienced a miscarriage			

If you have had any other symptoms, please describe them in the field below.

*** Have you ever experienced health problems (physical problems) during work?** □ **Yes** □ **No**

*** Do you think that you have health problems due to the materials you handle at work?** □ **Yes** □ **No**

Doctor's Comments	