MEDICAL HISTORY QUESTIONNAIRE

This questionnaire is for the purpose of obtaining a complete health profile and to comply with the Americans with Disabilities Act. Further, the information will allow your employer to evaluate and provide reasonable accommodation for any qualifying disability you may have. This information will be kept confidential in a separate medical file, apart from your personnel file.

IMPORTANT: Any employee who falsely represents his condition in writing at the time of entering into the employment relationship with the employer may be denied Worker's Compensation benefits; in addition, any false representation at this time may be subject the employee to termination.

NAME: ____ **SS#** ______________________________
ADDRESS: ______________________________________ **CITY:** ______________________ **ZIP:** _________________
TELEPHONE: ____________________ **D.O.B.:** ______________________ **POSITION:** __________________________
EMERGENCY CONTACT (NAME): ________________________ **TELEPHONE:** _____________ **RELATIONSHIP:** ______________

INSTRUCTIONS: **Circle "Y" for YES and "N" for NO** to the following questions and give dates for any yes answers. **Do not skip any questions**.

			Date
1. Severe headaches	N	Y	________
2. Dizziness or fainting spells	N	Y	________
3. Seizures	N	Y	________
4. Epilepsy	N	Y	________
5. Anemial/Hemophilia other blood disorder	N	Y	________
6. Rheumatic Fever	N	Y	________
7. Diabetes	N	Y	________
8. Hypoglecemia (low blood sugar)	N	Y	________
9. Cardiac Desease	N	Y	________
10. High Blood Pressure	N	Y	________
11. Varicose Veins or Leg Ulcer	N	Y	________
12. Thrombophlebetis (inflammation of vein or blood clot)	N	Y	________
13. Thyroid	N	Y	________
14. Hay fever/Asthma/Respiratory Disorder	N	Y	________
15. Chronic Cough	N	Y	________
16. Shortness of Breathe	N	Y	________
17. Chest Pain	N	Y	________
18. Bloody Sputurn	N	Y	________
19. Total deafness/hearing loss ear problems	N	Y	
20. Mental Retardation / Learning	N	Y	________
21. Eye/Vision conditions (glasses, contacts, color blindness, etc)	N	Y	________
22. Hernia (rupture)	N	Y	________
23. Ulcers	N	Y	________
24. Kidney or bladder trouble	N	Y	________
25. Hepatitis/Liver Disease	N	Y	________
26. Parkinson's Disease	N	Y	________
27. Skin Trouble	N	Y	________
28. Positive PPD (TB skin test)	N	Y	________
29. Tuberculosis	N	Y	________
30. Increased fatigue, night sweats	N	Y	________

			Date
31. Alcoholism/ Drug Addiction	N	Y	_______
32. Nervous breakdown, Mental Illness Psychiatric treatment or counseling	N	Y	_______
33. Arthritis / Rheumatism	N	Y	_______
34. Backaches	N	Y	_______
35. Head Injury	N	Y	_______
36. Neck or Back Injury	N	Y	_______
37. Leg/Knee/Hip/Ankle Injury	N	Y	_______
38. Elbow/Shoulder/Wrist/Arm/ Hand Injury	N	Y	_______
39. Repetitive Strain	N	Y	_______
40. Arthroscopy of a joint	N	Y	_______
41. Herniated (slipped) disc	N	Y	_______
42. Surgical removal of a disc or a spinal fusion	N	Y	_______
43. Knee Surgery	N	Y	_______
44. Any fracture or broken bones	N	Y	_______
45. Any other orthopedic surgery	N	Y	_______
46. Amputation pf a body part	N	Y	_______
47. Chronic Osteomyelitis (bone infection)	N	Y	_______
48. Osteoporosis	N	Y	_______
49. Residual Disability from polio	N	Y	_______
50. Muscular Dystrophy	N	Y	_______
51. Cerebral palsy	N	Y	_______
52. Multiple Sclerosis	N	Y	_______
53. Ankylosing Spondylitis	N	Y	_______
54. Have you ever had Chiropractic Treatment(s)	N	Y	_______
55. Complications	N	Y	_______
56. Disorders of immune system (answer is optional)	N	Y	_______

57. Are there any question(s) above that you do not understand?
If so, which number(s)? ______________________________

DO NOT WRITE BELOW THIS LINE – PLEASE REVIEW CAEFULLY TO BE CERTAIN THAT ALL QUESTIONS HAVE A RESPONSE. (TURN PAGE TO CONTINUE).

••

Review Comments:

____

____

____

____

____

____

____

INSTRUCTIONS: Circle "Y" for YES and "N" for NO to the following questions and give dates for any **Yes** answers. **Do not skip any questions**.

2.1 Please list any condition or diseases fro which you have been treated in the past 5 years. ____________________

____

2.2 Have you ever been hospitalized? **N** **Y** If so, for what? ____________________

____

2.3 Have you had a major illness / injury in the past 5 years? **N** **Y** Explain: ____________________

____

2.4 Have you had a CT Scan or MRI? **N** **Y** Explain: ____________________

____

2.5 Have you ever filed an occurrence / accident / injury report with a previous employer? N Y Explain: ____________________

____

2.6 Have you ever had an injury, operation, disease or any disability not covered by the previous questions (sports, recreational, MVA, liability)? **N** **Y** Explain:

____

____________________.

2.7 Have you ever had or been treated fro a Blood and Body Fluid Exposure (i.e. needle stick, splash, etc.)? **N** **Y** Explain : ____________________

____

2.8 Have you ever filed for Workers' Compensation Insurance, or received money in the form of lost wages / lump sum settlement as a result of a Workers' Compensation claim? **N** **Y** Explain: ____________________

____

2.9 Have you ever received any disability payments or settlements for inability to work? (Such as auto accidents, etc.) N Y Explain: ____________________

____________________.

2.10 Any permanent physical condition, which received an impairment ratings? **N** **Y** Explain: ____________________

____

2.11 Is there any health – related reasons you may not be able to perform the job, which you have been offered? **N** **Y** Explain: ____________________

____

2.12 Do you have any physical limitations, which prevent you from performing certain kinds of work? N Y If yes, please describe such specific work limitations / restrictions ____________________

2.13 Do you require any accommodations according to your job description? N Y If yes, Explain: ____________________

____

PLEASE DO NOT WRITE BELOW THIS LINE.

••

Reviewer Comments:

____

____

____

____

____

Please continue answering medical history questions:
3.1 Medication Allergies / Untoward Reactions? ____

____

3.2 Other Allergies or Sensitivities: ____

Latex: ____

3.3 Please list all Prescription Medications or Over The Counter Drugs that you take on a regular basis: ____

____

____

3.4 Have you ever worked around or been exposed to any of the following:
Chemotherapy **N Y** ___________ Radiation **N Y** _____________ Hazardous Chemical **N Y** ____________ Laser **N Y** _____________

When or Where? ____

3.5 Do you smoke / chew tobacco? **N Y** If yes, how much? Packs per week ___________ Number of years ____________

3.6 Please give dates you had the following diseases / immunization / exposures to:

CHICKEN FOX DATE:	RUBELLA (German Measles) DATE:	RUBEOLA (Red Measles) Date:	MMR (Mump/Meas/Rub) Date:	TETANUS/DIPTHERIA Date:
HEPATITIS A Date:	HEPATITIS B Date:	HEPATITIS B SERIES Date:	HEP B TITSER Date:	HEPATITIS C Date:

HEPATITIS B SCREEN If, in your position, you have the potential for exposure to Blood Borne Pathogens / Blood and Body Fluids, you must complete one of the following options:

A C C E P T A N C E

I have reviewed information on the Hepatitis B Vaccination Program and I choose to:
________ Request Series

I understand that it is my responsibility to contact Employee Health at Extension ________ to schedule an appointment and to receive the vaccine. This appointment is to be scheduled during the week of general orientation.

Signature: ______________________________ **Date:** ________________

D E C L I N A T I O N

I understand that due to my occupational exposure to blood or other potentially infectious materials. I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine at no charge to myself. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring Hepatitis B, a serious disease.
In the future I continue to have other occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.
_________ Decline Series, Previously Completed

Signature: _______________________________ **Date:** ________________

ALL STATEMENTS AND INFORMATION GIVEN IN THIS HISTORY ARE TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. THESE QUESTIONS WERE NOT ASKED OF ME UNTIL AFTER I WAS OFFERED A JOB.

I understand that my employment is contingent upon the approval of the physical assessment. I authorize the medical practitioner to disclose all relevant medical information to the Company regarding my medical history and assessment status.

Name (Printed) ____
Signature: ____ **Date:** _________________

Please do not write below this line.

Reviewer: Please review the form carefully to be certain that all questions have a response.
Reviewer Comments. ____

____

____