Health History

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The purpose of the following questions is to gather important information about your health so that the Occupational Health Department is aware of any medical problems in case of emergency, and to ensure that you can safely perform your job. Please place an (x) next to any of the following conditions if you have ever had them: **EXPLAIN "YES" ANSWERS ON BACK.**

Yes	No		
☐	☐	1.	Diabetes
☐	☐	2.	Hemophilia
☐	☐	3.	Tuberculosis
☐	☐	4.	Heart trouble, heart attack or chest pains
☐	☐	5.	Lack of sight in one or both eyes or vision not correctable to 20/20
☐	☐	6.	Thrombophlebitis (blood clot)
☐	☐	7.	Varicose veins
☐	☐	8.	Seizures or convulsions
☐	☐	9.	Asthma
☐	☐	10.	Breathing trouble or chronic respiratory disorder
☐	☐	11.	Allergies
☐	☐	12.	Ear trouble, poor hearing
☐	☐	13.	Frequent headaches, migraines
☐	☐	14.	Fainting or dizzy spells
☐	☐	15.	Mental illness or nervous disorder
☐	☐	16.	High blood pressure
☐	☐	17.	Liver disease
☐	☐	18.	Hernia
☐	☐	19.	Kidney trouble
☐	☐	20.	Stomach or intestinal problems
☐	☐	21.	Skin rashes or lesions
☐	☐	22.	Any kind of cancer, tumor, or blood disease
☐	☐	23.	Are you currently pregnant; if yes see back
☐	☐	24.	Any disease or condition which affects muscle control
☐	☐	25.	Any disease or condition affecting mobility of your extremities
☐	☐	26.	Arthritis, pain in joints
☐	☐	27.	Neck pain or limited movement
☐	☐	28.	Back pain, disc trouble, or limited movement
☐	☐	29.	Knee pain or limited movement
☐	☐	30.	Foot pain or limited movement
☐	☐	31.	Shoulder pain or limited movement
☐	☐	32.	Elbow pain or limited movement
☐	☐	33.	Wrist/forearm pain, numbness, tingling or limited movement
☐	☐	34.	Hand pain, numbness, tingling or limited movement
☐	☐	35.	Amputations
☐	☐	36.	Any other physical impairment or partial disability
☐	☐	37.	Do you use any medical assistive devices or equipment
☐	☐	38.	Do you have any type of work restrictions; if yes, explain on back
☐	☐	39.	Do you require any type of accommodations; if yes, explain on back
☐	☐	**40.**	**Upon review of the physical job requirement form presented by your recruiter, can you perform all the physical requirements of the job; if no, explain on back**
☐	☐	41.	Have you ever been rejected for insurance, employment or the Armed Forces for health reasons
☐	☐	42.	Have you ever filed a Worker's Compensation claim or received disability benefits as a result of a work-related injury or accident
☐	☐	43.	Have you used any medications in the past 6 months
☐	☐	44.	Have you ever been advised to limit use of or seek treatment for use of drugs or alcohol or been a member of Alcoholics Anonymous

When was your last tetanus shot _____

I hereby certify that I have answered the above questions to the best of my knowledge and that the answers are complete and true. I understand that false statements, misrepresentations, or omission of facts will be cause for dismissal.

Signature	Date
X	
Print name	

For Pregnancy Question - If yes, what is your due date? Are you currently under a physician's care for your pregnancy?

EXPLAIN "YES" ANSWERS BELOW:

Interviewer signature	Date
X	