

HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_  
                     Last                      First Middle                      Position                      Social Security Number

PERSONAL MEDICAL HISTORY: Please mark answers to all questions. Use reverse side if needed.

Have you ever had or have you ever been treated for:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
1. Allergies	_____	_____	24. Ionizing Radiation Injury	_____	_____
2. Amputated Foot, Hand or leg	_____	_____	25. Joint Injury or Pain	_____	_____
3. Ankylosis (fused joints)	_____	_____	26. Kidney Problems/Disease	_____	_____
4. Arthritis/Rheumatism	_____	_____	27. Heavy Metal Poisoning	_____	_____
5. Arteriosclerosis (hardening arteries)	_____	_____	28. Muscular Dystrophies (wasting of muscles)	_____	_____
6. Asthma/Bronchitis	_____	_____	29. Muscular Strain	_____	_____
7. Cardiac Disease or Heart Problems	_____	_____	30. Multiple Sclerosis	_____	_____
8. Cerebral Palsy	_____	_____	31. Neck or Back Injury	_____	_____
9. Cerebrovascular Disorder	_____	_____	32. Osteoporosis (loss of bone calcium - usually in women)	_____	_____
10. Osteomyelitis (bone infection)	_____	_____	33. Parkinson's Disease	_____	_____
11. Chronic Sore Throat	_____	_____	34. Poliomyelitis	_____	_____
12. Compressed Air Sequelae	_____	_____	35. Head Injury	_____	_____
13. Diabetes or Hyperinsulinism	_____	_____	36. Ruptured Intervertebral Disc	_____	_____
14. Epilepsy	_____	_____	37. Silicosis (lung condition from stone dust) or Asbestosis	_____	_____
15. Blindness (partial or complete) or eye problems	_____	_____	38. Skin Rashes	_____	_____
16. Fainting/Dizzy Spells	_____	_____	39. Spondylolisthesis (slippage of vertabrae from normal alignment)	_____	_____
17. Fractures	_____	_____	40. Thrombophlebitis (inflamed vein with clots)	_____	_____
18. Headaches	_____	_____	41. Tuberculosis or other lung problems/disease	_____	_____
19. Whole or partial loss of hearing or other ear problems	_____	_____	42. Varicose Veins	_____	_____
20. Hemophilia or Prolonged Bleeding	_____	_____	43. Hernia	_____	_____
21. Hemorrhoids or rectal bleeding	_____	_____	44. Other Problems, Diseases, Conditions	_____	_____
22. High Blood Pressure or Hypertension	_____	_____			

If any of your answers to the above questions are marked "yes", please provide a full explanation of the condition and any past or ongoing treatment on the reverse side. Please describe any restrictions on your physical activities which result from the condition.

Please answer the following questions. If the answer to any of these questions is "yes", please explain your answer.

Yes No

\_\_\_\_\_

Have you ever been hospitalized? If so, please state the date and place of hospitalization.

\_\_\_\_\_

Have you ever been advised by a medical physician to restrict your physical activities in any way? Please explain any restriction in detail.

\_\_\_\_\_

Are you currently taking any medication or drugs, whether by prescription or not?

\_\_\_\_\_

Have you ever undergone surgery? If so, when and where?

\_\_\_\_\_

Have you ever refused a recommended surgical procedure? If so, please describe the circumstances.

Employer does not discriminate in hiring, promotion or retention policies or practices against persons who have, in good faith, filed a claim for or received Workers' Compensation benefits. Employer does and will consider an individual's safety practices and mental and physical ability to carry out the essential job functions of the position applied for in making it's hiring decision.

I hereby certify that I have answered the above questions to the best of my knowledge and the answers are true and complete. I understand that misrepresentation or omission of facts is cause for dismissal and may result in denial of Workers' Compensation benefits.

Medical/Physical release: I hereby authorize any medical specialist or medical facility which has examined and/or treated me to provide my employer and/or Workers' Compensation carrier any information they may require as contained in your records.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_