Medical History

I certify that the information contained below is correct and complete to the best of my knowledge and belief. NOTICE: I understand that knowingly making a false statement or omission in this record may be deemed sufficient cause for withdrawl of my employment offer or dismissal after employment.

_____(Employee/ Applicant Initials)

EMPLOYEES JOB POSITION: _____

CHIEF COMPLAINT:_____

PAST MEDICAL HISTORY:

1. Have you had any medical problems or injuries previously? ___ YES ___ NO
   If YES, list: _____
   _____
2. Have you required hospitalization, had previous surgeries, had previous broken bones, orthopedic injuries/ problems or had workers' compensation injuries? ___ YES ___ NO
   If YES, list: _____
   _____
   _____
3. Are you under, or have you been under the care of a doctor at present for any ongoing medical problems? ___ YES ___ N0
   If YES, list care/treatment:_____
   _____
4. Are you on any prescription medication? Over-the-counter?
   ___ YES ___ NO If YES, list: _____
   _____
5. Are you ALLERGIC to any medication?___ YES ___ NO If YES, list: _____
   _____
6. Are you _____right or _____left hand dominant?
7. Do you smoke? ___YES ___NO #packs/day ___ #years smoked ___
8. Do you use smokeless tobacco? ___YES ___NO
9. Do you drink/ use alcohol?___YES ___NO #beers/day ___ #drinks/day ___
10. Date of last tetanus shot _____
11. Can you take a TB test YES/NO. Allergic or ever been exposed to TB? YES/NO
12. Have you received the Hepatitis B injection series? ___YES ___NO
13. Are you Pregnant? ___YES ___NO
14. Date of Last Menstrual Period?_____
15. Name of your personal physician:_____

PROBLEMS WITH OR HISTORY OF:

sugar or diabetes?	__YES __NO	thyroid problems?	__YES __NO
vision/eyes/cataracts/glaucoma?	__YES __NO	history of cancer?	__YES __NO
hearing/ears?	__YES __NO	kidney/bladder?	__YES __NO
lungs/asthma/bronchitis?	__YES __NO	arthritis/joint pain?	__YES __NO
anemia/bleeding problems/ bruise easily/leg clots?	__YES __NO	stomach/ulcers/ vomiting?	__YES __NO
history of heart problems?	__YES __NO	high blood pressure?	__YES __NO
nerve problems/anxiety/ depression?	__YES __NO	neurological problems/ numbness/weakness/tingling	__YES __NO
seizures past or present?	__YES __NO		
lymph gland swelling/ frequent infections?	__YES __NO	drug and/or alcohol abuse?	__YES __NO

PHYSICIAN Reviewing _____DATE _____