Employee Health History

To be completed by the employee/applicant:

Name: ____ **SS#**__________________________ **Date of Birth** ____________________________

Address: ____ **Phone:** ____

____ **Employer/Company Name:** ____

Please check any of the following illnesses that you have been diagnosed as having in the past or present.

_____ Diabetes
_____ High Blood Pressure
_____ Heart Disease
_____ Cancer
_____ Bleeding Disorder
_____ Hernia
_____ Back problems/injury
_____ Seizures/Epilepsy
_____ Hepatitis
_____ Tuberculosis
_____ Anemia
_____ Thyroid Disease
_____ Varicose Veins
_____ Stroke
_____ Ulcers
_____ Asthma
_____ Glaucoma
_____ Emphysema
_____ Frequent UTI's

Have you ever been hospitalized and/or had surgery (other than pregnancy)? ___________________
If yes, than please describe the illness and date:

Illness/Operation: Date: ______________
____ ______________
____ ______________

Please list all prescription and over-the-counter medications you are currently taking. Provide dosage if possible:
____
____

Please list any allergies you have. If you are allergic to a medication, please describe the nature of the reaction to the medication:
____
____

Please check any of the following problems you have had in the past or are currently having:

_____ Severe headache
_____ Difficulty hearing
_____ Visual difficulty
_____ Frequent sore throat
_____ Neck pain
_____ Back pain/injury
_____ Nervousness
_____ Racing of heart
_____ Weight Loss
_____ Recent change in appetite
_____ Frequent nausea or vomiting
_____ Severe abdominal pain
_____ Frequent diarrhea
_____ Chronic cough
_____ Chest pain
_____ Arthritis
_____ Joint Swelling
_____ Skin problems
_____ Head injury
_____ Dizziness
_____ Numbness/tingling
_____ Hernias
_____ Depression
_____ Swelling of feet or ankles

If you have any problems or illness not listed above or have additional comments about any item you checked above, please note them below:
____
____

I hereby certify that the information I have furnished on this form or to the examining physician is true and correct. I understand that falsification or omission may result in denial or dismissal from employment. I authorize the attending physician to disclose any findings made by him to the employer in regards to my employment.

____ _________________
Employee/Applicant **Date**

Name ____ D.O.B.______________

Vital Signs BP_______________ Pulse ________ Ht. _____________ Wt. ___________ Temp. ___________

	Normal	Abnormal	For Any Relevant Findings Please Make a Notation
General			
Skin			
Head			
Eyes			
Ears			
Nose/Throat			
Neck			
Lymph Nodes			
Chest/Lungs			
Heart			
Abdomen			
Extremities			
Back			
Neurological			

I have informed the applicant/employee of any abnormalities on the exam.

____ ______________

Signature of examining health care professional Date

PRE-EMPLOYMENT/ANNUAL PHYSICALS

______ Individual is capable of performing above indicated position.
______ Individual is not capable of performing above indicated position at this time.
______ Individual is capable of performing above indicated position with the following recommendations:
____
______ Further information is needed prior to making fitness for duty determination.
______ Based on the information obtained and physical examination, this individual appears to be free from communicable diseases.

____

Signature