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:

	Yes	No		Yes	No
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: _____