HealthWorks
Your Link to a Healthy Bottom Line

MEDICAL HISTORY

Name: ____________________ SSN: ____________ Birthdate: ____________ Age: ________

Address: ______________________________ Home Telephone: ______________

Position Applied For: ______________________________ Company ______________

APPLICANT/EMPLOYEE HEALTH HISTORY

Yes	No		Yes	No	
❑	❑	Any illness or injury in last 5 years	❑	❑	Stroke or paralysis
❑	❑	Head/Brain injuries, disorders or illness			
❑	❑	Seizures, epilepsy. If Yes, medication ______________	❑	❑	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
❑	❑	Eye Disorders or impaired vision (except corrective lenses)	❑	❑	Missing or impaired hand, arm, foot, leg, finger, or toe
❑	❑	Ear disorders, loss of hearing or balance	❑	❑	Numbness or tingling of arms, legs, hands or feet
❑	❑	Heart disease or heart attack; other cardiovascular condition. If Yes, medication: ______________	❑	❑	Spinal injury or disease
❑	❑	Diabetes or elevated blood sugar Controlled by _____ diet _____ pills _____ insulin	❑	❑	Have you had any exposure to chemicals, noise or vibration which might cause possible health problems? If yes, please list: ______________
❑	❑	High Blood Pressure. If Yes, Medication: ______________	❑	❑	Chronic or ongoing low back pain
❑	❑	Muscular disease/joint pain/carpal tunnel syndrome/tendonitis	❑	❑	Regular, frequent alcohol use
❑	❑	Shortness of breath	❑	❑	Narcotic or habit forming drug use
❑	❑	Lung disease, emphysema, asthma, chronic bronchitis	❑	❑	Tobacco use. If yes, how much: ______________
❑	❑	Kidney disease, dialysis	❑	❑	Any other disease or illness: ______________
❑	❑	Liver disease	❑	❑	Do you have any hobbies? If Yes, please list: ______________
❑	❑	Digestive problems/ulcers/colitis			
❑	❑	Nervous or psychiatric disorders (e.g. severe depression). If Yes, medication ______________	❑	❑	Do you have any cancer or illness that tends to occur in your family? If Yes, please list: ______________
			❑	❑	What jobs or types of work have you performed in the past? Please list ______________
❑	❑	Loss of, or altered consciousness			
❑	❑	Fainting, dizziness			

For any Yes answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

How much work time have you lost in the last 2 years due to illness or injury? ______________

Please list any past surgeries (operations): ______________

Please list any allergies: ______________

Have you had (answer Yes or No): Measles ❑ Yes ❑ No Mumps: ❑ Yes ❑ No
German Measles (Rubella): ❑ Yes ❑ No Chicken Pox: ❑ Yes ❑ No

If you were born in 1957, or more recently, have you had 2 measles or MMR immunizations? ❑ Yes ❑ No

I certify that the above information is complete and true. I understand that inaccurate, false, or missing information may invalidate the examination.

Signature ______________________________ Date ______________

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