

Medical History Form

Last Name	First	MI	Sex	Date of Birth	Social Security Number
Local Address (No. and Street)			City	State	Zip
Telephone Number					
Place of Birth	Job Title	Department or Unit	Supervisor	Dept/Unit Phone	
Emergency Contact	Telephone	Personal Medical Provider	Telephone		

Personal Health History

Have you EVER HAD, or do you have, any of the following? Check EACH item. If yes, specify by number and explain:

	No	Yes		No	Yes
1. Chicken pox or shingles	☐	☐	25. Broken bones	☐	☐
2. Measles	☐	☐	26. Bone or joint problems	☐	☐
3. Mumps	☐	☐	27. Arthritis/gout	☐	☐
4. Skin problems or chronic rash	☐	☐	28. Back pain/injury	☐	☐
5. Eye problems	☐	☐	29. Numbness/tingling legs or feet	☐	☐
6. Hearing loss or ear problems	☐	☐	30. Knee pain/injury	☐	☐
7. Chronic cough	☐	☐	31. Foot pain/injury	☐	☐
8. Asthma	☐	☐	32. Neck pain/injury	☐	☐
9. Shortness of breath	☐	☐	33. Loss of limb	☐	☐
10. Lung problems	☐	☐	34. Severe headaches	☐	☐
11. Tuberculosis or positive TB skin test	☐	☐	35. Dizziness or fainting	☐	☐
12. Chest pain	☐	☐	36. Epilepsy or seizures	☐	☐
13. Heart trouble/attack	☐	☐	37. Severe weakness or tiredness	☐	☐
14. Palpitations/irregular heart beat	☐	☐	38. Depression or anxiety	☐	☐
15. Heart murmur	☐	☐	39. Emotional or psychiatric problems	☐	☐
16. High blood pressure	☐	☐	40. Drug or Alcohol dependency	☐	☐
17. Stroke or paralysis	☐	☐	41. Eating disorder	☐	☐
18. Stomach or intestinal problem	☐	☐	42. Bleeding or blood disorder	☐	☐
19. Liver disease/hepatitis	☐	☐	43. Immune suppression	☐	☐
20. Kidney disease	☐	☐	44. Chronic/recurrent infection	☐	☐
21. Weight change	☐	☐	45. Tumor/cancer	☐	☐
22. Thyroid problems	☐	☐	46. Anemia	☐	☐
23. Shoulder/elbow/wrist/hand pain	☐	☐	47. Diabetic	☐	☐
24. Numbness/tingling of arms or hands	☐	☐	48. Any other illness not listed	☐	☐

Please Check Each Item, If YES, specify by number and explain:

- [illegible]

I certify that the information documented on this form is **true and complete** to the best of my knowledge. I understand that misrepresentation or omission of facts may prevent my employment or may be cause for termination after beginning employment.

Date

Comments by Clinician: