Employee Health Assessment Form

Title: Employee Health Assessment Form

Employee Information:

- **Full Name: _____**
- **Employee ID: _____**
- **Department: _____**
- **Position/Title: _____**
- **Contact Number: _____**

Health History:

- **Previous Illnesses/Injuries: _____**
- **Current Medications: _____**
- **Known Allergies: _____**
- **Recent Medical Procedures: _____**

Lifestyle Information:

- **Smoking Status: [ ] Yes [ ] No**
- **Alcohol Use: [ ] Yes [ ] No**
- **Physical Activity Level: [ ] Low [ ] Moderate [ ] High**

Vaccination Record:

Vaccine	Date Received	Booster Due	Comments
Flu Vaccine			
COVID-19			

Hepatitis B			
Tetanus			

Employee Declaration: I confirm that the above information is accurate to the best of my knowledge.

Signature: _____

Date: _____