**Employee Health Assessment Form**

**EMPLOYEE INFORMATION QUESTIONNAIRE**

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Name (print last, first, middle) SS# Birth Date Phone

Address City State Zip

Emergency Contact & Number Relationship

Department Position Sex (M, F) Marital Status (S, M, W, D)

Personal Physician & Number

FAMILY HEALTH HISTORY

Has a family member (parents, siblings, grandparents) had any of the conditions listed? Diabetes \_ \_

Cancer \_ \_

Heart Disease \_ \_ High Blood Pressure \_\_

Tuberculosis \_\_

PERSONAL HEALTH HISTORY

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Back Injuries  Seizures, fainting, dizziness | Y  {  { | es  }  } | No  {  { | }  } | Heart Disease  Stomach Ulcer | Y  {  { | es  }  } | No  {  { | }  } | Permanent defect from illness, disease, injury | Y  { | es  } | No  { | } |
| Any type allergies | { | } | { | } | Rheumatic fever | { | } | { | } | Stomach, gall bladder trouble | { | } | { | } |
| Tuberculosis | { | } | { | } | Hearing difficulty | { | } | { | } | Smoker (amount) | { | } | { | } |
| Any type Hepatitis, jaundice | { | } | { | } | Kidney disease | { | } | { | } | Drink alcohol (amount) | { | } | { | } |
| Nervous disorder | { | } | { | } | Muscular disease | { | } | { | } | Ever injured on the job | { | } | { | } |
| Respiratory disease | { | } | { | } | Mental illness | { | } | { | } | Women-pregnant at this time | { | } | { | } |
| High Blood Pressure | { | } | { | } | Hernia | { | } | { | } | Incapacitated by pain during period | { | } | { | } |
| Arthritis, gout, joint disease | { | } | { | } | Diabetes | { | } | { | } | Vision difficulty, eye disease | { | } | { | } |
| Cancer | { | } | { | } | Headaches | { | } | { | } | Ear, nose, throat trouble-sinus, colds | { | } | { | } |
| Receiving medical treatment at the present time or in the past 6 months | | | | | | | | | | | { | } | { | } |
| Ever been turned down for life insurance, military service, or employment for physical reasons | | | | | | | | | | | { | } | { | } |

If answer to any of the above is yes, explain:

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\_ \_ \_ \_ \_ \_ \_

Medication Allergies \_ \_ \_ \_ \_ \_ \_ \_ Medications Now Taking \_ \_ \_ \_ \_ \_ \_ Last Tetanus Vaccination: \_ \_ \_ \_ \_ \_

Childhood diseases: Had Immunized Did not have, not immunized, appropriately instructed

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Chicken pox | { | } | { | } | { | } |
| Red Measles (Rubeola) | { | } | { | } | { | } |
| Mumps | { | } | { | } | { | } |
| German Measles (Rubella) | { | } | { | } | { | } |

Would you say your present health is: { } Excellent { } Good { } Fair { } Poor

This information is true and correct to the best of my knowledge.

Signature of Applicant/Employee \_ \_ \_ \_