

HEALTH HISTORY (The following information is requested to determine your current health status.) Please Print or Type.

Name (Last, First, Middle Initial)	Sex	Age	Birthdate	Social Security No.	Date Form Completed
Address (Street, City, State, Zip)			Home Phone	Cell Phone	Pager
Name/Phone No. of Person to Notify in Case of Emergency			Name of Personal Physician/Address		

Please Check If You Have Been Immunized For:

- Mumps Polio Varicella
 Rubella (German Measles) Rubeola (Red Measles) List Year _____
 Diphtheria Tetanus (List Year) _____
 Hepatitis B Series (List Dates: 1 _____ 2 _____ 3 _____)

Please Check If You Have Ever Had:

- Chicken Pox/Shingles Polio Scarlet Fever Rubella (German Measles)
 Hepatitis Type: _____ Rubeola (Red Measles) Rheumatic Fever Malaria
 Mumps AIDS/HIV TB (Tuberculosis)

Do You Have Any Allergies to Drugs, Dust, Pollen, Grasses, Eggs, Feathers, Foods, etc.?

Yes No List: _____

Smoking:

Current Yes No _____ pack/day _____ years
 Past Yes No _____ pack/day _____ years

Please List Medications You Are Currently Taking (Include Vitamins, Birth Control Pills):

Name	Dosage	When Did You Start Medication

PERSONAL HISTORY SURGERY: Exclude Uncomplicated Pregnancies

YEAR	PLACE	ILLNESS/OPERATION	DOCTOR

MAJOR ILLNESS/INJURIES (Include if you have ever had broken bones, burns)		Outcome:
YEAR	ILLNESS	

WORK HISTORY

What was your occupation prior to this job? _____

Describe any part of your past job that you feel may be hazardous to your health? _____

Did you wear protective equipment on this job? If Yes, specify: _____

In that job, were you exposed to any of the following?

Fumes/Dust	Yes	No	Vapors	Yes	No	Heavy Lifting	Yes	No	Emotional Stress	Yes	No
Metals	Yes	No	Heat/Cold	Yes	No	Gases	Yes	No	Chemicals	Yes	No
Solvents	Yes	No	Noise	Yes	No	Radiation	Yes	No			

Have you ever transferred from/or left a job because of:

If Yes, give brief description.

Sensitivity to chemicals, dust, sunlight, etc.	Yes	No	_____
Inability to perform certain motions.	Yes	No	_____
Inability to assume certain positions.	Yes	No	_____
Other medical reasons.	Yes	No	_____
Applied for, or received Worker's Compensation.	Yes	No	_____
Any time lost from work for past 2 years due to illness or injury.	Yes	No	_____

SUPPLEMENTAL - PERSONAL HISTORY

Date

Any brace or support worn?	Yes	No	_____
Have you ever lived or travelled outside the Continental U.S.A.?	Yes	No	_____
Do you have hobbies that expose you to chemicals/metals?	Yes	No	_____
Any history of a positive T.B. skin test?	Yes	No	_____
Give date of last chest x-ray. Any history of abnormal findings?	Yes	No	_____
Have you ever had any special studies such as x-ray pictures, heart studies, or special blood examinations?	Yes	No	_____

I HEREBY CERTIFY THAT:

- I have carefully read and completed the foregoing information in the Health Questionnaire and that my answers and explanations are true, to the best of my knowledge and belief. I understand that an omission or falsification of any of the information I have provided herein will be cause for discharge.
- I understand that this and other medical information will be held in strict confidence. It will be released only where required by law. Non-confidential information regarding work restrictions relating to job assignment will be provided to management and personnel.
- I consent to the physical assessment by the Community Health Network and it's agents.
- I understand that the purpose of the examination is for my placement and employment and that Community Health Network has no obligation to treat or diagnose existing conditions.

Employee Signature: _____

Date: _____