

**Occupational Medicine Center
Health Exam Questionnaire**

The purpose of this questionnaire is to gather information concerning your health and physical condition, both now and in the past. This information will be used only to determine whether you can safely and adequately perform the duties of the job which you have been offered.

Name: _____ Male [] Female [] Date of Birth _____
 Address: _____ Telephone # _____

Employment / Exposure History

Please read carefully and answer all questions on the front and back side of this page.
 List your last 6 jobs, job title, type of work and any health hazards. Write "Y" for yes or "N" for no in regards to any affect on your health.

Name of Employer	From Month/Year	To Month/Year	Job Title	Description of Work	List Hazards	Any Health Affects? Y / N

Work / Service History

1. Have you ever been injured in a vehicle accident? If yes, please explain below. Yes [] No []
2. Have you ever had any work-related injuries or illnesses? If yes, please explain below. Yes [] No []
3. Did you ever receive, or do you have pending, a compensation award or pension for a work-related injury or illness? Yes [] No []
4. Have you ever received a veteran's pension for a service connected disability? Yes [] No []
5. Have you ever been rejected for life insurance or by the Armed Forces for medical reasons? Yes [] No []

Explain all "yes" answers to the above questions.

Medical History

Are you now under a doctor's care? Yes [] No [] If yes, give details. _____

List Hospitalizations and Surgeries:

Date	Reason for hospitalization or surgery:	Hospital Name:

List all medications you are currently taking, both prescription and over the counter medications:

Family History

Is there a family history of heart disease, high blood pressure, diabetes, or cancer? Yes [] No [] If yes, comment below.
 Are your parents and siblings alive and well? Yes [] No [] Do they have any health problems? Yes [] No [] If yes, comment below. If deceased, what was the cause of death, if known?

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals or clinics mentioned above to furnish the Sansum-SBMFC Occupational Medicine Center with copies of my medical record for purposes of further evaluation in relation to this application for employment. I authorize the examining physician to release information from this examination to the employer for whom this exam is being conducted.

Name of Employer _____

Printed Name _____ Signature _____ Date _____

