MED CENTER℠

Date: _____

PRE-EMPLOYMENT MEDICAL HISTORY

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NO.		DATE OF BIRTH	CITIZENSHIP
STREET ADDRESS			CITY	STATE	ZIP CODE	HOME PHONE
COMPANY APPLIED TO		ADDRESS				
POSITION APPLIED FOR						

Have You Ever Had or Do You Now Have Any of the Following: (If "yes" answered to any of the following, explain below)

	YES	NO		YES	NO
1. Anemia or blood disease	☐	☐	21. Sugar or albumin in urine	☐	☐
2. Heart trouble, rheumatic fever or heart murmur	☐	☐	22. Kidney or bladder trouble	☐	☐
3. High blood pressure	☐	☐	23. Frequent headaches or migraine	☐	☐
4. Chest pain or angina	☐	☐	24. Dizziness, fainting spell, epilepsy, fits	☐	☐
5. Shortness or breath	☐	☐	25. Nervousness or mental illness	☐	☐
6. Frequent colds or persistent cough	☐	☐	26. Paralysis, nerve disease or injury	☐	☐
7. Disease of the lungs	☐	☐	27. Severe injury	☐	☐
8. Allergy, hay fever, asthma	☐	☐	28. Broken bones or head injury	☐	☐
9. Eye trouble	☐	☐	29. Joint or back injury	☐	☐
10. Deafness or ear trouble	☐	☐	30. Arthritis, bursitis, ganglion	☐	☐
11. Major illness	☐	☐	31. Bone or joint disease	☐	☐
12. Operations	☐	☐	32. Back problem or ruptured disc	☐	☐
13. Skin disease or other rash	☐	☐	33. Venereal disease (gonorrhea, syphilis)	☐	☐
14. Varicose veins or leg sores	☐	☐	34. Metal or other poisoning	☐	☐
15. Cancer, tumor or cyst	☐	☐	35. Recent gain or loss in weight	☐	☐
16. Stomach or intestinal trouble (incl. nervous stomach)	☐	☐	**For women only**		
17. Jaundice (liver or gall bladder trouble)	☐	☐	1. Female disorders	☐	☐
18. Hemorrhoids, rectal bleeding	☐	☐	2. Painful or irregular menstruation	☐	☐
19. Hernia or rupture	☐	☐	3. Date of last menstruation _____		
20. Diabetes or thyroid disease	☐	☐	4. No. or pregnancies _____ No. or children _____		

Have You Ever Had (If "yes" answered to any of the following, explain below)

	YES	NO		YES	NO
1. Been denied employment for health reasons	☐	☐	11. Had problems from work with vibrating tools	☐	☐
2. Been refused application for life insurance	☐	☐	12. Lost time from work due to illness or injury during the past 5 years	☐	☐
3. Filed an industrial disability claim	☐	☐	13. Been under the care of a physician for any reason in the past year	☐	☐
4. Served in the Armed Forces	☐	☐	14. Taken medication for several months or years	☐	☐
5. Been rejected for service in the Armed Forces	☐	☐	15. Been on street drugs or on methadone program	☐	☐
6. Been discharged from the Armed Forces other than honorably	☐	☐	16. Are you now taking drugs or medication	☐	☐
7. Been convicted of a felony	☐	☐	17. Do you smoke	☐	☐
8. Had health problems from exposure to harmful chemicals, solvents, fumes, or dust at work or elsewhere (mining, sandblasting, foundry, asbestos, cotton, ect.)	☐	☐	How much _____		
9. Had health problems from material or substances harmful to skin or blood	☐	☐	18. Do you drink alcoholic beverages	☐	☐
10. Developed hearing problems from exposure to noise	☐	☐	How much _____		
			19. Were you ever a heavy drinker	☐	☐
			When _____		

Preplacement Back Survey

	YES	NO		YES	NO
1. History of time lost from work for back injury	☐	☐	4. Current back pain	☐	☐
2. Back surgery	☐	☐	5. Pains running down your legs	☐	☐
3. Seeing a doctor or chiropractor for back problems	☐	☐	6. Worker's Compensation claim for back problem	☐	☐

Please explain "yes" answered to any of the above questions:

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