

Preplacement Health History Questionnaire and AssessmentName _____ Male Female Date of Birth _____

Home Address _____

Home Phone _____ Cell _____ SocSec# _____

Your EMAIL _____

Company you are applying for _____ Department _____

Position you are applying for _____

Introduction:

The information you provide in this questionnaire is extremely important. It will be used by a physician or health care professional to evaluate your ability to perform the essential functions of the job safely without endangering yourself or others. Please fill out the questionnaire completely and accurately so that an employment decision can be made which will benefit both you and your employer.

All statements are subject to verification; and deliberate inaccuracies or incomplete statements may bar or remove you from employment.

Please answer all questions completely. Do not leave any answers blank; use either "NA" (not applicable) or "Don't Know".

1. List your last 3 hospitalizations (excluding routine childbirth):

Date	Age	Condition	Name of Hospital, City & State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. List any other operations or surgeries not included above:

Date	Age	Condition	Name of Hospital, City & State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. **Date of Immunizations:** Tetanus _____ Hepatitis B series complete _____ Rabies _____

4. List all Medications (prescription and non-prescription) that you are currently taking (including vitamins, aspirin, antihistamines, cold medication, reducing aids, recreational drugs, etc):

5. List all meds (prescription and non-prescription) not listed above that you have taken in the past two months:

6. Exercise

What do you do for exercise? _____

#days/week _____ #minutes/day _____

7. Do you have, or have you ever had:

- No Yes ? Vision problems (color/night blindness, blurred vision, glaucoma, cataract, other)
- No Yes ? Skin condition (recurrent eczema, irritated skin, open lesions)
- No Yes ? Hearing problems No Yes ? Headaches
- No Yes ? Dizziness/fainting/loss of consciousness No Yes ? Convulsions/seizures/epilepsy
- No Yes ? Depression or emotional disorder No Yes ? Psychological problems/stress
- No Yes ? Prior drug/alcohol treatment No Yes ? Chronic Fatigue/Gulf War Syndrome
- No Yes ? Asthma/shortness of breath No Yes ? Chronic cough
- No Yes ? Tuberculosis No Yes ? Pneumothorax
- No Yes ? Chest pain or heart problems No Yes ? Swollen ankles or varicose veins
- No Yes ? Heart murmur/irregular heart beat No Yes ? High blood pressure
- No Yes ? Diabetes No Yes ? Thyroid problems
- No Yes ? Hepatitis No Yes ? Ulcer/irritable bowel/Crohn's Disease
- No Yes ? Anemia No Yes ? Bleeding tendency
- No Yes ? Cancer or leukemia No Yes ? Bad reaction to cold, heat, heights or closed spaces
- No Yes ? Hernia No Yes ? Numbness of extremities
- No Yes ? Carpal tunnel syndrome No Yes ? Fractures (broken bones)
- No Yes ? Sleep Apnea

Chronic or recurring pain or limited motion associated with:

- Neck
- Wrist
- Back
- Ankle
- Shoulder
- Hand
- Hip
- Foot
- Elbow
- Knee

Please Check One – “No” “Yes” “?”

- 8.. Do you drink alcoholic beverages at least once per week? No Yes ?
- 9. Do you smoke cigarettes at least once per week? No Yes ?
- 10. Are you currently taking any drugs or illegal substances not authorized by your physician or health care professional for medical purposes? No Yes ?
- 11. Have you ever had a reaction, allergy, and/or sensitivity to any drugs (such as codeine, penicillin, or sulfa), latex, foods, plants, or chemicals? No Yes ?
- 12. Are you currently under medical care for any emotional or physical illnesses? No Yes ?
- 13. Have you been advised to have any operations which have not yet been done? No Yes ?
- 14. Have you ever had an injury at work? No Yes ?**
When?: _____
- 15. Do you currently have a workers' compensation or disability claim pending? No Yes ?
- 16. Are you currently receiving any medical disability payments (SDI, VA, LTD, SSI, etc.)? No Yes ?
- 17. Have you ever changed jobs or work assignments because of any health problems or injuries? No Yes ?
- 18. Have you ever had a physician or health care professional give you activity restrictions? No Yes ?
- 19. Have you missed more than one week of work, due to health reasons, in the last year? No Yes ?

20. Have you ever seen a physician or health care professional because of any back/neck/joint problems? No Yes ?
- 21. Have you ever been off work because of any back/neck/joint problems?** No Yes ?
22. Have you had menstrual problems that kept you off work? No Yes ?
23. Have you ever been absent from work due to job stress? No Yes ?
24. Do you take medications at work or before work which you believe could affect your physical or mental function or performance? No Yes ?
25. Have you ever been unable to hold a job or refused employment because of any physical, mental or other health related reason? No Yes ?
26. Have you ever been rejected or discharged from a military position because of any physical, mental or other health related reason? No Yes ?
27. Within the past year, have you had repeated feelings of numbness, tingling, or "pins and needles" sensations in one or both hands?..... No Yes ?
28. Within the past year, have you had repeated feelings of soreness or pain in either forearm or elbow?..... No Yes ?
29. Have any of the above symptoms (numbness, tingling, soreness or pain) caused you to be awakened while sleeping?..... No Yes ?
30. Does discomfort in your wrist, arm or shoulder interfere with your daily activities (eating, writing, sports, etc.)? No Yes ?
31. Have you ever received medical treatment for this pain and/or discomfort? No Yes ?
32. Does your present job require arm, hand, or finger actions to be repeated many times each hour or work shift?..... No Yes ?
33. Please mark on the diagrams below where, in the past year, you have had:



