



MEDICAL HISTORY QUESTIONNAIRE

The object of this form is to avoid assignment which may be injurious to health.

Name: _____
(Last) (First)

SS#: _____ Title: _____ Branch: _____

Applying for Job as _____ Personal Physician _____

Have you ever in the past 5 years...	YES or NO	If YES, Explain
been operated on, been advised to have an operation, been a patient in hospital, sanitarium or institution?		
been seriously injured?		
been refused employment for health reasons OR been forced to give up a job because of health?		
received Workmen's Compensation?		
been rejected for military service for health reasons OR been discharged for health reasons?		
received a pension for disability?		
been refused insurance or driver's license for health reasons?		
Is there any reason you cannot wear a surgical mask for up to twelve (12) hours for infection control purposes?		
Do you need glasses/contacts to read? for distance?		
Have you ever worked with radioactive material?		
Have you ever had seizures or convulsions?		
Do you take medicine regularly?		
Have you ever injured your back?		
Have you ever worn a back brace or knee brace?		
Have you ever had a head injury?		
Do you ever use a hearing aid?		
Have you ever had a rupture, wear a truss?		
Have you ever had radiation therapy?		
Are you now or have you ever used habit forming drugs? (i.e., stimulants, depressants/narcotics)		
Are you now or have you ever had a problem with alcohol?		
Have you ever had:	YES or NO	If YES, Explain
Diabetes		
High Blood Pressure		
Tuberculosis		
Nervous Breakdown		
Heart Trouble		
Varicose Veins		
Arthritis		
Allergies		
In the last 12 months have you...	YES or NO	If YES, Explain
Been diagnosed with tuberculosis		
Taken care of a patient with active TB		
Lived in the same household with someone with active TB		
Had your PPD convert to positive		
Been on anti-tuberculosis medications		
Had a persistent cough with unexplained weight loss		

The above statements are true to the best of my knowledge. Any misstatement of fact is grounds for release.

 Date Signature of Applicant

Person to be Notified in Case of an Emergency: _____

Address: _____ Telephone Number: _____

Do not write below this line DATE OF LAST PHYSICAL EXAM

REMARKS:
Date _____ RN/MD SIGNATURE _____