HEALTH QUESTIONNAIRE (Fill In Completely)

NAME _____ SS NO. _____ DATE _____

(STREET) (CITY & STATE) (ZIP CODE) ( ) AREA CODE

ADDRESS _____ PHONE NO. _____

BIRTH DATE	HEIGHT	WEIGHT	SINGLE MARRIED DIVORCED	SEPARATED WIDOW WIDOWER	NUMBER OF DEPENDENTS

IN THE EVENT OF EMERGENCY CONTACT:

NAME _____

( ) Area Code Phone Number _____ Relationship _____

POSITION APPLIED FOR _____

FORMER EMPLOYER: _____

YOUR DOCTOR'S NAME _____

DOCTOR'S ADDRESS _____

FAMILY RECORD

	LIVING		DECEASED		
	AGE	HEALTH	AGE AT DEATH	DATE OF DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHERS					
SISTERS					
SONS					
DAUGHTERS					

This questionnaire is for the purpose of assisting the employment department in placing you in a job safe to yourself and others according to your physical ability. A physical impairment does not necessarily disqualify you. Your cooperation in answering the following questions is requested:

DIRECTIONS:
If you answer YES to the question, put a circle around the "YES" and give details on page 3.
If you answer NO to the question, put a circle around the NO.

1. Do you have bad vision? ..... Yes No
2. Are your eyes often red or inflamed? ..... Yes No
3. Are you hard of hearing? ..... Yes No
4. Have you ever had a bad running ear? ..... Yes No
5. Do you have constant noises in your ears? ..... Yes No
6. Have you ever had T.B. (Tuberculosis)? ..... Yes No
7. Do you get hay fever? ..... Yes No
8. Do you suffer from asthma? ..... Yes No
9. Do you have trouble with your feet? ..... Yes No
10. Does a weak back or back pain make it hard for you to do some types of work? ..... Yes No
11. Have you ever seen a medical doctor, osteopath or chiropractor regarding your back? ..... Yes No
12. Have you ever had a backache? ..... Yes No
13. Have you ever had an injury to your back? ..... Yes No
14. Has a doctor ever said your blood pressure was too high? ..... Yes No
15. Do you have pains in the heart or chest? ..... Yes No
16. Are you allergic to any foods, dust, animals, vegetation? ..... Yes No
17. Have you every had sinus trouble? ..... Yes No
18. Are you troubled by constant coughing? ..... Yes No
19. Have you ever coughed up blood? ..... Yes No
20. As a child did you have rheumatic fever, growing pains or twitching of the limbs? ..... Yes No
21. Has a doctor ever said you had kidney or bladder disease? ..... Yes No
22. Have you ever had serious liver or gall bladder trouble? ..... Yes No
23. Are your joints often painfully swollen? ..... Yes No
24. Have you ever had pains in your leg? Sciatica? ..... Yes No
25. Is your skin sensitive? ..... Yes No
26. Have you had skin disease? ..... Yes No
27. Do you suffer from frequent severe headaches? ..... Yes No
28. Was any part of your body ever paralyzed? ..... Yes No
29. Were you ever knocked unconscious? ..... Yes No
30. Have you ever had epilepsy? ..... Yes No
31. Has a doctor ever said you had a hernia? ..... Yes No
32. Did a doctor ever treat you for tumor or cancer? ..... Yes No
33. Do you suffer from any chronic disease? ..... Yes No
34. Did a doctor every say you have varicose veins (swollen veins)? ..... Yes No
35. Did you ever have an operation? ..... Yes No
36. Did you ever have a serious injury? ..... Yes No
37. Have you any scars on your face or body? ..... Yes No
38. Have you ever injured your knees? ..... Yes No
39. Have you ever fractured or broken a bone? ..... Yes No
40. Have you ever worked in a mine, foundry brick yard, pottery, quarry, or as a sand blaster or stone cutter? ..... Yes No

Give details on all questions answered "Yes"

41. Do you smoke? ..... Yes No
    cigarettes a day? _____
42. Have you ever been rejected for service in the Armed Forces for any medical or physical condition? ..... Yes No
43. Have you ever been rejected for life insurance? ..... Yes No
44. Have you had any medical treatment during the past three years? ..... Yes No
45. Have you ever received any disability payments? ..... Yes No
46. Have you ever received a disability rating? ..... Yes No
47. Have you ever had an on-the-job injury? If yes, state name of employer and the date of the injury ..... Yes No
48. Have you or any member of your family ever had diabetes? ..... Yes No
49. Have you ever worked around any of the following substances? (If so, explain operation and exposure level.)

( ) asbestos
( ) lead
( ) carbon monoxide
( ) quartz, talc, silicone
( ) coal dust
( ) ethylene oxide
( ) fibrous glass dust
( ) formaldehyde
( ) gypsum
( ) oil mist or fumes
( ) benzene
( ) wood dust
( ) cement dust
( ) chromium
( ) acrylonitrile
( ) chromates
( ) vinyl chloride monomer
( ) welding fumes
( ) ethylene bromide
( ) beryllium
( ) petroleum fuels
( ) toluene
( ) xylene
( ) pesticides
( ) cleaning solvents such as acetone, alcohols, degreasers, trichloroethylene, methyl ethyl ketone, chloroform, and any substance listed as a carcinogen or suspect carcinogen. (Specify)

50. Are you currently using any prescription or non-prescription drugs?
    List below name and purpose:

Name of Drug	Purpose

51. Are you currently using any of the following substances?
    marijuana ..... Yes No
    amphetamines ..... Yes No
    barbiturate ..... Yes No
    LSD ..... Yes No
    cocaine ..... Yes No
    heroin ..... Yes No
    PCP ..... Yes No
    methadone ..... Yes No
52. Do you drink alcohol? ..... Yes No
    If yes, daily consumption _____
53. Have you been diagnosed as Hemophiliac? .... Yes No
54. Do you have arthritis or rheumatism? ..... Yes No
55. Have you ever been diagnosed as having:
    – Carpal Tunnel Syndrome ..... Yes No
    – Tendonitis ..... Yes No
    – Ganglion Cysts ..... Yes No
56. Do you often experience pains in the arms, wrists, or fingers? ..... Yes No
57. Have you ever had a diagnosis for neurological disorders? ..... Yes No
58. Have you ever been diagnosed as having any type of psychiatric or psychological disorder? .. Yes No
59. Have you had any illness or disease not included in the above questions? ..... Yes No

Give details on all questions answered "Yes". Indicate question number.