SPECTRUM HEALTH

MEDICAL HISTORY - OCCUPATIONAL HEALTH

Name ____________________ Date of birth ____________ Age ____

Job Title (applied for) ______________________________

HAVE YOU EVER HAD A HISTORY OF ANY OF THE FOLLOWING? CHECK "YES" OR "NO" THEN EXPLAIN BELOW

YES	NO	
☐	☐	1. Head injury or concussion?
☐	☐	2. Dizziness, fainting?
☐	☐	3. Seizures?
☐	☐	4. Migraine headaches?
☐	☐	5. Asthma or shortness of breath with activity?
☐	☐	6. Heart problem, murmur, or chest pain?
☐	☐	7. High blood pressure?
☐	☐	8. Stomach problems, ulcers, heartburn?
☐	☐	9. Liver problems/hepatitis?
☐	☐	10. Hernia?
☐	☐	11. Kidney problems?
☐	☐	12. Diabetes, sugar problems?
☐	☐	13. Anemia, blood clots, or bleeding problems?
☐	☐	14. Cancer?
☐	☐	15. Pain or injury to any joint?
☐	☐	16. Broken or fractured bones?
☐	☐	17. Carpal tunnel syndrome
☐	☐	18. Weakness or numbness in arms or hands?
☐	☐	19. Weakness or numbness in legs or feet?

YES	NO	
☐	☐	20. Neck or back pain or injury?
☐	☐	21. Do you have any restrictions or physical limitations? Explain: ____________
☐	☐	22. Depression, anxiety, or mental disorder?
☐	☐	23. Been treated for a drug or alcohol problem?
☐	☐	24. Do you smoke, chew, or vape tobacco?
☐	☐	25. How many alcoholic drinks do you have per week? ________
☐	☐	26. Any allergies or reactions to latex or medications?
☐	☐	27. Any hospitalization overnight (other than for surgery listed or childbirth)?
☐	☐	28. Could you be pregnant?
		29. List your surgeries: ____________
		30. List your medications: ____________

Explain ALL"yes" answers marked above

NOTICE TO EXAMINEE: This employment examination is conducted for the sole benefit of your employer. This examination is not designed to discover, diagnose or treat any illness or condition you may have. You should consult your own physician on a regular basis for such examinations. Your signature authorizes release of all information regarding health history, examination, and recommendations to the above employer and/or its insurers. I hereby certify that I have read the above information and that my answers are true and correct to the best of my knowledge.

Employee signature ______________________________ Date ____________

HEALTH CARE PROVIDER'S Signature ______________________________ Date ____________

Comments:

☐ Smoking cessation advice provided

CONFIDENTIAL