REPORT TITLE :

Pre-Placement Occupational Medical History Questionnaire

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

Name (Last, First, Middle):	Last 4 of Social Security Number:	Date of Birth:
Job Location:	Job Title/Position:	Telephone Number:
I certify that the following information is true to the best of my knowledge. Signature: Date:		Email:

Please answer the following questions regarding your medical history and health habits. This information will be used to make an assessment of whether you can safely and effectively perform job duties, and will be handled in a confidential manner. Providing false or incomplete responses could result in loss of this employment opportunity or loss of compensation.

DO YOU NOW HAVE OR HAVE YOU EVER HAD THE FOLLOWING CONDITIONS?

	Yes	No
1. Frequent/severe headaches		
2. Vision problems/color blindness		
3. Glaucoma/cataracts/colorblindness		
4. Hearing loss/ear abnormality		
5. Chronic sinusitis		
6. Balance/vertigo		
7. Goiter/thyroid problem		
8. Chronic or productive cough		
9. Frequent colds		
10. Wheezing/asthma/breathing problems		
11. Lung disease/bronchitis/pneumonia		
12. Chest pain/pressure/angina		
13. Shortness of breath		
14. Hypertension (high blood pressure)		
15. Heart attack/congestive heart failure		
16. Heart murmur/irregular heart beat		
17. Frequent diarrhea/constipation		
18. Change in bowel habits/blood in stool		
19. Unexplained weight gain or loss		
20. Jaundice/hepatitis		
21. Kidney or bladder problems		
22. Blood in urine/frequent or painful urination		
23. Recurrent fever/night sweats		
24. Hemorrhoids/rectal problems		
25. Arthritis/joint pain/rheumatism/bursitis		
26. Foot problems/flat feet/leg cramps		
27. Broken bone/skeletal problems		
28. Leg/arm problems		

	Yes	No
29. Neck stiffness/cervical strain/whiplash		
30. Amputation		
31. Back pain/injury/abnormality		
32. Carpal tunnel syndrome		
33. Epicondylitis (tennis elbow)		
34. Numbness/tingling/tremors		
35. Paralysis/weakness		
36. Skin problems (eczema/hives/infection)		
37. Cancer/tumor		
38. Diabetes/pre-diabetes/elevated blood sugar		
39. Gout		
40. Stroke		
41. Memory loss		
42. Epilepsy/seizures/fainting/dizziness		
43. Depression/other mental health problems		
44. Drug or alcohol abuse/treatment		
45. Sleep problems/sleep apnea		
46. Varicose veins/ankle swelling		
47. Rheumatic fever		
48. Tuberculosis/chest disease		
49. Hernia		
50. Anemia/blood problems		
51. Multiple chemical sensitivity		
52. Fibromyalgia/chronic fatigue		
53. High cholesterol		
54. Allergies (food/medicine/mold/dust)		
55. HIV/AIDS/immune-compromised condition		
56. Other illness/medical condition not listed		

Explain all YES answers on Page 2

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Name (Last, First, Middle):	Last 4 of Social Security Number:

Explain all YES answers from Page 1. List NUMBER of each question, then explain the condition (Diagnosis, Treatment, if Resolved, and if you Still Have the condition). Example: 27. Broken bone, right arm, age 12, no surgery, resolved, no current problem.

Have you ever <u>Worked</u> in the following Places:

	Yes	No
Chemical plant		
Construction site		
Cotton, flax, or hemp plant		
Electronic plant		
Farm		
Fiber plant		
Foundry or mine		
Outdoor areas		
Paper/lumber plant		
Refinery or shipyard		
Dusty job site		
Other job sites with hazardous exposures		

Have you ever <u>Used</u> or <u>Been Exposed</u> To:

	Yes	No
Arsenic		
Benzene		
Cadmium		
Extreme temperatures		
Dust		
Lead		
Mercury		
Pesticides		
Phosgene		
PVC (polyvinylchloride)		
Silica		
Spray painting		
Welding/soldering		

	Yes	No
Asbestos		
Beryllium		
Carbon tetrachloride		
Chromates		
Flourides		
Loud noise		
Lasers		
Phenols		
Plastics		
Radioactive material		
Solvents/degreasers		
Trichloroethylene		
Other hazardous chemicals		

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Name (Last, First, Middle):	Last 4 of Social Security Number:

If YES, please explain:

	Yes	No
57. Do you have any concerns about your health as it relates to the job?		
58. Do you now receive, or have you ever received, compensation from a government agency for a service-related disability?		
59. Have you ever received Workers' Compensation for an injury or illness?		
60. Do you have a claim pending concerning Workers' Compensation?		
61. Have you ever lost time from work because of a job injury or illness?		
62. Do you have a permanent impairment or any activity restrictions?		
63. Have you ever had to leave a job due to a medical problem or due to a permanent limitation or restriction?		
64. Are you unable to perform any particular motion or activity?		
65. Do you require a job modification to accommodate an impairment?		
66. Is there any function or part of the job that you cannot perform?		
67. Do you currently have any health problem which poses a potential risk to co-workers or which might interfere with the performance of the job?		
68. Do you currently have any pain?		
69. Are you currently receiving medical treatment for any condition?		
70. Do you use any prostheses or medical devices?		

Such as artificial limbs, colostomy devices, braces, etc.

71. Have you had any surgeries or operations?		

List date and type of procedure.

72. Have you ever been admitted to a hospital?		

List date and reason for admission

73. Are you currently taking any medications?		

List any medication used on a regular basis, including prescription and non-prescription drugs (such as vitamins, cold remedies, aspirin or other over-the-counter medications).