EMPLOYEE HEALTH SERVICES
PRE PLACEMENT HEALTH HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to help the Employee Health Services Provider determine your ability to perform the essential job/duties for the position for which you have been offered. It is also a tool to help assess whether accommodations are appropriate or required.

Name____ Date of Birth_____________

Address____ Phone#__________________
____ SS#_____________________

Name of family physician___________________________ Date of last exam_________

Relative to the job for which you applied, is there any health-related condition for which you require accommodation, i.e., job modification, structural changes to the work area? If so, please list below:

1.____
2.____
3.____

Can you fully perform all duties that your employment work will require?
☐Yes ☐No, explain____
____

Have you been unable to hold a job due to:

a. Sensitivity to chemicals, dust, sunlight, etc.,?
b. Inability to perform certain motions?
c. Inability to assume certain positions?
d. Other medical, emotional or physical reasons?

If yes to any of the above, please explain:_____________________________________
____

Personal Health History-Illness

1. Chicken pox/shingles	☐yes	☐no	7. Rheumatic fever	☐yes	☐no
2. Hepatitis A,B,C	☐yes	☐no	8. Chest discomfort	☐yes	☐no
3. Tuberculosis	☐yes	☐no	9. Heart disease	☐yes	☐no
4. Positive TB skin test (PPD)	☐yes	☐no	10. Heart murmur	☐yes	☐no
5. Bleeding disorder	☐yes	☐no	11. Irregular heart beat	☐yes	☐no
6. Physical disability	☐yes	☐no	12. Mitral valve prolapse	☐yes	☐no

Personal Health History – Illness (continued)

13. High blood pressure	☐yes	☐no	26. Asthma/lung disease	☐yes	☐no
14. Fainting spells/dizziness	☐yes	☐no	27. Recent weight change	☐yes	☐no
15. Frequent indigestion	☐yes	☐no	28. Tumor/cancer	☐yes	☐no
16. Peptic ulcer disease	☐yes	☐no	29. Depression/excessive worry	☐yes	☐no
17. Intestinal disease	☐yes	☐no	30. Drug/alcohol dependency	☐yes	☐no
18. Liver disease	☐yes	☐no	31. Chronic/recurrent infection	☐yes	☐no
19. Kidney Disease/stones	☐yes	☐no	32. Loss of Limb	☐yes	☐no
20. Diabetes	☐yes	☐no	33. Shortness of breath	☐yes	☐no
21. Thyroid problem	☐yes	☐no	34. Anxiety or panic disorder	☐yes	☐no
22. Vision problem	☐yes	☐no	35. Anemia	☐yes	☐no
23. Hearing problem	☐yes	☐no	36. Hernia/rupture	☐yes	☐no
24. Fractures	☐yes	☐no	37. Any other illness or chronic disease not listed		
25. Severe headaches	☐yes	☐no			

Explain all yes answers:____

____

____

____

Would you say your present health is: ☐ Excellent ☐Good ☐Fair ☐Other
If other, please explain:____

____

____

Have you ever had an operation? ☐yes ☐no
If yes, please explain:____

____

____

Any chronic or reoccurring pain or limited motion associated with:(if yes, please explain)

Neck? ☐yes ☐no,____

Back? ☐yes ☐no,____

Arm? ☐yes ☐no,____

Wrist? ☐yes ☐no,____

Hand? ☐yes ☐no,____

Hip? ☐yes ☐no,____

Knee? ☐yes ☐no,____

Leg? ☐yes ☐no,____

Have you consulted or been treated by Physicians, Therapists, Chiropractors or other Practitioners within the past five (5) years? ☐yes ☐no
If yes, please explain:____

____

Any skin or other health-related conditions which cause recurrent eczema, irritated skin or open skin lesions? ☐yes ☐no
If yes, please explain:____

____

Allergies and Exposures
Do you have any food or drug allergies? ☐yes ☐no
If yes, please explain:____

____

Are you allergic to Latex? ☐yes ☐no

Have you ever had a reaction to dust, plants or chemicals? ☐yes ☐no
If yes, please explain:____

____

Medications
Are you taking any medications? ☐yes ☐no
If yes, please list:____

____

Do you take medication while at work or before work which you believe could affect your physical or mental function or performance? ☐yes ☐no
If yes, please explain:____

____

I hereby certify that all the facts stated in this questionnaire are true to the best of my knowledge and belief. Further, I understand the following:

- *That I may be required to provide additional medical information and/or undergo further medical evaluation to properly complete the assessment.*
- *That Crouse Hospital and/or the examining provider undertake no responsibility to ensure either a thorough examination or thorough report to myself, it being understood that such examinations are conducted for exclusive benefit of Crouse Hospital.*

____ _________________________
Signature Date