Employee Medical Health Assessment

NAME: ______________________________ **TODAY'S DATE:** ______________________

PHONE NUMBER: **BIRTHDATE:**

ADDRESS:

JOB STATUS: (Circle or Highlight) Travel/Contract PRN/Per Diem

JOB POSITION: **START DATE (Filled out by HR):**

NAME & FACILITY OF FAMILY PHYSICIAN/PRIMARY CARE PROVIDER:
If you do not have a Physician/Primary Care Provider, write NA. DO NOT LEAVE BLANK.

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YOU MUST COMPLETE THIS SECTION OR SUBMIT A RECENT PHYSICAL FROM YOUR PHYSICIAN (WITHIN PAST 12 MONTHS)

Do you have or have you ever been treated for the following?
DO NOT LEAVE BLANK

- Heart Disease
- Lung Disease/Asthma
- History of a Positive Tuberculosis skin test/QuantiFERON Gold test
- Drug therapy for Tuberculosis
- Kidney Disease
- Hepatitis C
- Epilepsy
- Hepatitis B
- I do not have any of the above

Do any of the following conditions apply to you?
DO NOT LEAVE BLANK

- AIDS

- Cancer
- Chemotherapy
- Currently taking Steroid Medications
- History of organ transplant
- HIV
- Immunosuppressant medication
- Leukemia
- Lupus
- Lymphoma
- Radiation Therapy/Treatment
- I do not have any of the above

In reference to eyesight, do any of the following apply to you?
DO NOT LEAVE BLANK

- Contact lenses
- Prescription glasses
- Non-prescription reading glasses
- Legally blind
- Not applicable

Any hearing difficulties or do you use a hearing device?

- Yes
- No

Have you received treatment for any medical condition or injury in the past twelve (12) months? *If yes, describe. If no, write NA*

Please list all surgeries and hospitalizations that you have had in the past 12 months and approximate dates. *If none, write NA*

In the past 12 months, have you had pain, numbness or weakness in any of these areas?

- Back
- Shoulder
- Neck
- Arm
- Wrist
- Hand
- Hip
- Ankle
- Knee
- Does not apply

Please check below to indicate any conditions that you have experienced in the last 12 months or are currently experiencing. *IF NOT APPLICABLE, PLEASE CHOOSE "NONE OF THESE APPLY"*

- Loss of balance or dizziness
- Brace and/or appliance use
- Infectious disease exposure
- Tendonitis and/or carpal tunnel
- Back injury
- Lifting restrictions
- Workers' Compensation injury
- Physical or mental limitations and/or restrictions that would keep me from performing the essential functions of this position
- None of these apply

Have you ever been discharged or rejected from the armed forces due to illness or injury?

- Yes
- No

Have you ever received disability income under any State or Federal Law?

- Yes
- No

Have you ever left or been asked to leave a job due to health related injury and/or disease?

- Yes
- No

Have you ever had a work related injury or medical problem?

- Yes
- No

Have you ever received compensation for an illness or injury?

- Yes
- No

Do you use tobacco?

- Yes
- No

If yes, what type and how much per day?

How many alcoholic beverages do you consume per week?

Do you take any medications regularly?

- Yes
- No

If yes, please list medications & reasons for taking

Do you see a physician regularly for a medical problem?

- Yes
- No

Has any physician advised you to have a surgical operation that you have not had yet?

- Yes
- No

Have you ever been told by a physician that you have a latex sensitivity?

- Yes
- No

Check any allergies you have from the list below:

- Bananas
- Avocado
- Raw potatoes
- Apples
- Chestnuts

Check any sensitivities you have from the list below:

- Balloons
- Rubber gloves
- Hot water bottles
- Elastic undergarments
- Foam pillows

By completing this form, I, ______________________ (Print Name), consent to the disclosure of this information to healthcare facilities and Vendor Management Systems ONLY in regard to my employment.

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Your Signature **Date**

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Converdia HR Signature **Date**