Holy Family Memorial
Sponsored by the Franciscan Sisters of Christian Charity

Name:_____

Please answer the following questions as completely and honestly as you can.

Do you currently or have you ever had any of the following health conditions? If yes, please give approximate date as well.

1. ALLERGIES

Yes	No	Date
☐	☐	_____ to Medication?
☐	☐	_____ Foods or chemicals?
☐	☐	_____ Hay fever?
☐	☐	_____ Asthma?
☐	☐	_____ Latex?

2. BACK AND NECK

Yes	No	Date
☐	☐	_____ Back pain/stiffness?
☐	☐	_____ Back injury?
☐	☐	_____ Back surgery?
☐	☐	_____ Neck pain/stiffness?
☐	☐	_____ Neck injury?
☐	☐	_____ Neck surgery?

3. STOMACH/INTESTINES

Yes	No	Date
☐	☐	_____ Ulcer?
☐	☐	_____ Gallbladder?
☐	☐	_____ Frequent heartburn/stomach pain?
☐	☐	_____ Recent change in bowel habits?
☐	☐	_____ Lack of appetite?
☐	☐	_____ Passed blood from rectum?
☐	☐	_____ Hemorrhoids?
☐	☐	_____ Rupture or hernia?

4. EXTREMITIES

Yes	No	Date
☐	☐	_____ Fractured bones?
☐	☐	_____ Shoulder pain/injury?
☐	☐	_____ Elbow pain/injury?
☐	☐	_____ Wrist pain/injury?
☐	☐	_____ Hand pain/injury?
☐	☐	_____ Knee pain/injury?
☐	☐	_____ Ankle pain/injury?
☐	☐	_____ Foot pain/injury?
☐	☐	_____ Arthritic joints?
☐	☐	_____ Varicose veins?

5. HEART/LUNGS

Yes	No	Date
☐	☐	_____ Lung disease?
☐	☐	_____ Short of breath or cough?
☐	☐	_____ Palpitations/fluttering

5. HEART/LUNGS cont:

Yes	No	Date
☐	☐	_____Chest pain?
☐	☐	_____Heart attack
☐	☐	_____Heart surgery
☐	☐	_____High Blood Pressure?

6. HEAD - eyes, ears, nose, throat

Yes	No	Date
☐	☐	_____ Frequent headaches/migraines?
☐	☐	_____ Eye injury/surgery?
☐	☐	_____ Cataracts/glaucoma?
☐	☐	_____ Any problems with vision? (other then glasses/contacts)
☐	☐	_____ Color blindness?
☐	☐	_____ Any problems with ears?
☐	☐	_____ Hearing loss?
☐	☐	_____ Any major dental problems?
☐	☐	_____ Sinus trouble?
☐	☐	_____ Frequent colds?

7. GENITOURINARY SYSTEM

Yes	No	Date
☐	☐	_____ Kidney or bladder infection?
☐	☐	_____ Kidney stones?
☐	☐	_____ Frequent or painful urination?
☐	☐	_____ Blood in Urine?

Females:

☐	☐	_____ Treatment for any female disorders?

Males:

☐	☐	_____ Treatment for testicular or prostate problems?

8. NEUROLOGICAL

Yes	No	Date
☐	☐	_____ Head injury?
☐	☐	_____ Frequent dizziness/fainting?
☐	☐	_____ Memory lapses?
☐	☐	_____ Frequent tremors/shakiness/loss of balance?
☐	☐	_____ Trouble with coordination/organization?
☐	☐	_____ Specific neurological disease?
☐	☐	_____ Pain radiating down the arm?
☐	☐	_____ Numbness/tingling in arm/hand?
☐	☐	_____ Waking up during night with numbness/ pain in fingers or hands?
☐	☐	_____ Numbness or pain in fingers/hand while driving?
☐	☐	_____ Numbness/tingling in leg/foot?
☐	☐	_____ Seizures?
☐	☐	_____ Frequent trouble sleeping?

9. SKIN/HAIR/NAILS

Yes	No	Date
☐	☐	_____ Skin diseases or sensitivities?
☐	☐	_____ Lesions removed?
☐	☐	_____ Lacerations?
☐	☐	_____ Identifying marks (tattoos, etc.)?
☐	☐	_____ Recent change in appearance of wart/mole?

10. DISEASE/CONDITIONS

Yes No Date

☐ ☐ _____ Anemia, blood disorders?
☐ ☐ _____ Diabetes?
☐ ☐ _____ Rheumatic fever/scarlet fever?
☐ ☐ _____ Tuberculosis?
☐ ☐ _____ Hepatitis?
☐ ☐ _____ Epilepsy?
☐ ☐ _____ Pneumonia/pleurisy?
☐ ☐ _____ Bronchitis?
☐ ☐ _____ Emphysema?
☐ ☐ _____ Benign lump, growth?
☐ ☐ _____ Cancer?
☐ ☐ _____ Shingles?
☐ ☐ _____ Thyroid disorder?
☐ ☐ _____ Chronic fatigue?
☐ ☐ _____ Other?

11. MEDICAL/HOSPITALIZATION HISTORY

Yes No Date

☐ ☐ Have you ever been hospitalized for surgery, illness? injury or childbirth? If yes, please give dates & diagnosis. _____

_____

☐ ☐ Have you been treated for any health condition in the past 12 months? If yes, please describe._____

12. OCCUPATIONAL HEALTH HISTORY

How much time have you lost from work or school during the past two years due to illness?_____

☐ ☐ Date

☐ ☐ Have you ever been rejected for employment, insurance or the armed forces because of your physical condition? _____

☐ ☐ Have you ever been off of work due to a work-related injury? If yes, how long?_____Type of injury:_____

☐ ☐ Have you ever been given a disability rating? If yes, when and what percent? _____

☐ ☐ Do you currently have any mental/emotional problems which could possibly affect your job performance? If yes, describe problem & treatment._____

13. TAKING MEDICATIONS

Yes No List here:_____

☐ ☐ _____

14. HEALTH HABITS

☐ Yes ☐ No Do you smoke or use tobacco products? If yes, describe_____

☐ Yes ☐ No Do you drink alcoholic beverages? If yes, how much_____

Have you worked at a job or hobby which involved exposure to any of the following? If so, please check all that apply:

☐ Asbestos	☐ Chromium	☐ Isocyanates (MDI,TDI)	☐ Pesticides/Herbicides	☐ Solvents
☐ Benzene	☐ Cytotoxic Dru	☐ Lead	☐ Plastics/ Resins	☐ Uranium
☐ Beryllium	☐ Epoxy Compounds	☐ Mercury	☐ Radiation	☐ Urethanes
☐ Cadium	☐ Formaldehyde	☐ Anesthesia Gases	☐ Rock Dust	☐ Vinyl Chloride
☐ Carbon Disulfide	☐ Hexame	☐ Nickel	☐ Silica Dust	☐ Welding Fumes
☐ Chromat	☐ Hydofluoric Acid	☐ Noise (severe)	☐ Ethylene Oxide	☐ X-Rays
			☐ Carbon Monoxide/Smoke	☐ Cyanide

☐ Yes ☐ No Are you on a special diet? If yes, what type?_____

☐ Yes ☐ No Do you exercise regularly? If yes, what type of exercises and how often? _____

CONSENT STATEMENT

I, _____, have received a contingent offer of employment at Holy Family Memorial, and voluntarily consent to a pre-placement medical examination, medical history, and diagnostic tests to be performed by Holy Family Memorial and/or its designee. If a condition is discovered that indicates the need for further treatment, I understand that I am personally and financially responsible for any medical care I choose to obtain based on these findings. I understand that this record and report shall become a part of my employee health file which will be maintained as confidential information. I declare the information I have given is accurate and understand any misrepresentation, omission of information, or the failure or neglect to disclose any information requests, may be grounds for termination regardless of when such falsification, misrepresentation, failure or neglect may be discovered. I further understand that the offer extended to me is contingent on my ability to perform the minimum physical requirements of the job based in part on the findings of this medical examination. Verification of immunity to communicable diseases will be entered in Wisconsin Immunization Registry and results of annual Tb skin testing may be released to potential employers upon my request. I hereby release and authorize Health Care provider to release the report of the results of this exam and any laboratory tests, including drug screens, to my employer, provided, however, that this information is kept confidential and will only be disclosed to other individuals as authorized by law. In order to comply with GINA Title II, we request that you do not provide genetic information.

_____

Applicants Signature Date