



Medical Questionnaire

Employee Name: _____ Date: _____

Have you ever suffered from or experienced any of the following conditions or problems?		YES	NO
1.	Disorder of the eyes, ears, nose or throat?		
2.	Fainting, convulsions, paralysis, stroke, psychiatric or neurological disorder?		
3.	Allergies, emphysema, bronchitis, asthma or any other disorder of the lungs?		
4.	Heart or circulatory condition, high blood pressure or persistent chest pain?		
5.	Gastrointestinal, liver or gall bladder disorder?		
6.	Diabetes, thyroid or any other endocrine disorder?		
7.	Anemia or any other disease, which affects your blood or immune system?		
8.	Skin disorders, cyst, tumor or problem with your lymph glands?		
9.	Surgical operations within the last 10 years?		
10.	Exposure to tuberculosis, hepatitis or any other contagious disease?		
11.	Smoked or used any tobacco product in the last year?		
12.	Any work related injury?		
13.	Filed a Worker's Compensation Claim?		
14.	Arthritis, back pain, gout or any disorder of the kidney, bladder, prostate or reproductive organs?		
15.	Venereal disease or any other disorder of the kidney, bladder, prostate or reproductive organs?		
16.	Use of heroin, cocaine, hallucinogens, tranquilizers, barbiturates, amphetamines or other narcotics which were not prescribed by a duly licensed physician?		
17.	Treatment, advice or counseling from a physician or other health care practitioner relating to mental illness or your use of drugs or alcoholic beverages?		
18.	Any condition or limitation (bending, carrying, etc.) which would restrict you in part of in full, from performing any of the requirements of the job?		
19.	Any preferences we should take into consideration when placing you on an assignment (i.e. patients diagnosis, location, environment, etc.)?		
20.	Are you currently under the care of a Physician, Chiropractor or any other helping professional?		

Please explain all "Yes" responses below:

Signature: _____ Date: _____