WellStar Medical Group
Occupational Medicine
Post Offer Physical Examination Medical Questionnaire

PLEASE READ CAREFULLY AND SIGN:
Instructions: This questionnaire must be completed by all prospective employees for medical examination purposes. All applicable questions must be answered.

I certify that all information provided in this questionnaire is true and correct to the best of my knowledge. I understand that any falsification or omission of any information requested herein will be considered sufficient cause for discharge without prior warning at any time during my employment or assignment at

____.
Employer Name Here

Date: ____________ Applicant's Signature: ____

SECTION I:

Name: _________________________________ Job: __________________________________
Today's Date: _______________ Department: ___________________ Shift: 1 2 3 Weekends
Social Security #: _____________ Home Address: ____
City/State: _________________________ Zip: _________ Home Telephone: ____________________
Date of Birth: __________________ Age: ______ Sex: ______
Notify in Case of Emergency: __________________________ Home Telephone: ___________________

SECTION II:

Have you ever been treated for any of the following medical problems?

	YES	NO		YES	NO		YES	NO
1. Recent Weight Loss or Gain	___	___	19. Neck Injury	___	___	32. Hemophilia	___	___
2. Multiple Sclerosis	___	___	Shoulder Injury	___	___	33. Leukemia	___	___
3. Muscular Dystrophy	___	___	Arm / Hand Injury	___	___	34. Frequent Headaches	___	___
4. Chronic Osteomyelitis	___	___	Leg / Foot Injury	___	___	35. Anemia	___	___
5. Heart Murmur / Heart Attack	___	___	Eye Injury	___	___	36. Chest Pains	___	___
6. Heart Disease	___	___	20. Sickle Cell Anemia	___	___	37. Ulcers	___	___
7. Rheumatic Fever	___	___	21. Lost Time from Injuries	___	___	38. Hernia	___	___
8. High Blood Pressure	___	___	22. Phlebitis	___	___	39. Hepatitis	___	___
9. Fainting or Dizzy Spells	___	___	23. Arthritis	___	___	40. Diabetes	___	___
10. Epilepsy or Convulsions	___	___	24. Kidney Problem	___	___	41. Thyroid Disorder	___	___
11. Circulatory Problems	___	___	25. Cerebral Palsy	___	___	42. Pneumonia	___	___
12. Cancer	___	___	26. Vision Problems	___	___	43. Aids	___	___
13. Back Aches or Back Injury	___	___	27. Latex Allergies	___	___	44. Asthma	___	___
14. Carpel Tunnel	___	___	28. Disc Problems	___	___	45. Amputations	___	___
15. Chronic Skin Problems	___	___	29. Tuberculosis	___	___	46. Parkinson's Disease	___	___
16. Skin Rashes or Boils	___	___	30. Chronic Cough	___	___	47. Date of Last EKG _____________		
17. Eating Disorder	___	___	31. Psychiatric Treatment	___	___			
18. Anorexia / Bulimia	___	___	or Counseling					

Explain all "YES" answers (include approximate dates of treatment): ______________________________

____

SECTION III:

Have you had the following childhood diseases or immunizations?

Measles ____ Rubella ____ Chicken Pox ____ Mumps ____ Flu Vaccine ____

Date of last: Tetanus Shot: ____________ Heptavax/Recombivax: ____________ Pneumovax: ____________

SECTION IV:

Please answer all of the questions.

		YES	NO
1.	Have you ever had a positive TB test?	____	____
2.	To your knowledge, have you ever had a BCG vaccine? (This is not the same as a skin test)	____	____
3.	Have you ever been rejected for blood donation?	____	____
4.	Are you allergic to any drugs, medications, or other substances?	____	____

5. Have you ever been treated for or diagnosed as an alcoholic?
   Frequency of alcohol use: None ____ Daily ____ Weekly ____ Infrequently ____

6. Have you ever used the following drugs or narcotics without a physician's order?

	Yes	No		Yes	No		Yes	No		Yes	No
Heroin	___	___	Morphine	___	___	LSD	___	___	Cocaine	___	___
Marijuana	___	___	Methadone	___	___	Opium	___	___			

		YES	NO
7.	Have you ever been addicted to or dependent upon any other types of drugs or narcotics?	____	____

Explain all "YES" answers (including approximate date): ____

____

____

8. Do you smoke? ❑ Yes ❑ No How much? _________________ For how long? ______________

SECTION V:

Please answer all of the questions. Explain all "YES" answers and include approximate dates in space provided at the end of Section V.

		YES	NO
1.	Are you presently under a physician's care for medical or surgical problems?	____	____
2.	Do you have any physical limitations, handicaps or disabilities?	____	____
	If so, do they require special arrangements?	____	____
3.	Have you ever been disqualified or discharged from the armed services for a medical problem?	____	____
4.	Have you ever been treated or hospitalized for a psychiatric or mental health problem?	____	____
5.	Have you ever or are you now undergoing psychotherapy?	____	____
6.	Have you ever lost time from work due to a major illness or injury?	____	____
7.	Have you ever had a job related accident or injury?	____	____
8.	Have you ever received or applied for disability insurance benefits for any medical condition or injury?	____	____
9.	Have you ever had a back injury?	____	____
	Do you have curvature of the spine or scoliosis?	____	____
	Have you ever been treated for either of the above?	____	____

	YES	NO
10 Do you have a hearing problem?	____	____
Do you wear a hearing aid?	____	____
11. Do you anticipate any surgery, hospitalization, or major medical treatment within the next 12 months?	____	____
12. Have you been hospitalized in the past 10 years?	____	____

13. List all physicians, psychiatrists and/or psychologists who have treated you within the past 5 years:

____

____

Private physician's name: ______________________________ Phone: ____________________

Address: ____

14. List all medications you take regularly: ______________________________________

____

____

Special instructions from private physician, such as diabetes, epilepsy, etc. ____________________

____

____

	YES	NO
15 Date of last dental exam: ______________________		
Dentures?	____	____
16. Date of last eye exam: ______________________		
Glasses?	____	____
Contacts?	____	____

FEMALE APPLICANTS ONLY:

	YES	NO
17. Have you had a history of sexually transmitted disease?	____	____
Are you pregnant?	____	____
Estimated date of delivery: ________________________		
Do you have severe menstrual cramps?	____	____
How often? ____________________		
Date of last mammography ________________		
Date of last pap smear ________________		
Age of menopause or hysterectomy __________		

MALE APPLICANTS ONLY:

	YES	NO
18. Have you had a history of sexually transmitted disease?	____	____
Have you had inguinal hernia?	____	____
Testicular pain?	____	____
Testicular masses?	____	____
Difficulty starting or stopping a stream?	____	____

Explain all "YES" answers (including approximate date): ________________________________

____

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____

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SECTION VI:

COPIES OF YOUR LABORATORY, X-RAY, AND PHYSICAL ASSESSMENT RESULTS ARE AVAILABLE UPON REQUEST FOR YOU TO TAKE TO YOUR PRIVATE PHYSICIAN.

PLEASE READ CAREFULLY AND SIGN:

I authorize any hospital, clinic, or physician to release to WellStar Occupational Medicine information relative to my medical history, physical and mental condition for purposes of (1) verifying the information provided on this form, (2) approving disability insurance benefits or (3) determining my ability to perform my assigned job duties. I further agree that this authorization will be reviewed on a need-to-know basis by management. Medical information provided will be reviewed by the WellStar Occupational Medicine Medical Director as appropriate and final decision on employment will be based on the Medical Director's recommendation.

Date: ____________ Applicant's Signature: ____

Thank you!