

ST. MARY'S OCCUPATIONAL MEDICINE PRE-PLACEMENT QUESTIONNAIRE

COMPANY: _____ EMPLOYEE: _____ SS#: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

DEPT: _____ SEX: _____ DATE OF LAST TETANUS SHOT: _____

POSITION APPLIED FOR: _____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

ALLERGIES (MEDICATION, FOOD, ETC.): _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

EARS, EYES, NOSE, THROAT YES NO

- 1. EAR DISEASE OR INJURY
- 2. LOSS OF HEARING
- 3. DO YOU WEAR CONTACT LENSES
- 4. DO YOU WEAR GLASSES
- 5. EYE DISEASE
- 6. HAY FEVER
- 7. OTHER

LUNGS

- 1. TUBERCULOSIS
- 2. OTHER LUNG DISEASE
- 3. ASTHMA
- 4. OTHER

HEART AND CIRCULATION

- 1. HEART DISEASE
- 2. HIGH BLOOD PRESSURE
- 3. FAINTING OR DIZZY SPELLS
- 4. OTHER

GASTROINTESTINAL/ABDOMEN/PELVIC

- 1. DIABETES
- 2. HERNIA (RUPTURE)
- 3. STOMACH TROUBLE
- 4. KIDNEY TROUBLE
- 5. OTHER

BONES/JOINTS

- 1. BROKEN BONE/FRACTURE
- 2. FOOT TROUBLE
- 3. PAINFUL BACK OR NECK
- 4. PAINFUL JOINTS
- 5. ARTHRITIS OR RHEUMATISM
- 6. OTHER

HEAD/NEUROLOGICAL YES NO

- 1. SEIZURES (CONVULSIONS)
- 2. MIGRAINES OR FREQUENT HEADACHES
- 3. HEAD INJURY
- 4. NERVOUS CONDITION
- 5. OTHER

OTHER

- 1. SKIN DISEASE OR RASH
- 2. CANCER
- 3. NERVOUS CONDITION
- 4. SERIOUS INJURY THAT REQUIRED MEDICAL ATTENTION
- 5. WERE YOU EVER HOSPITALIZED FOR ILLNESS OR OPERATION
- 6. HAVE YOU BEEN IN THE MILITARY
BRANCH _____ YEAR _____ TO _____
IF YES, WERE YOU DISCHARGED FROM THE SERVICE FOR HEALTH REASONS
- 7. DO YOU HAVE ANY DISABILITY RATINGS, PERMANENT OR OTHERWISE
- 8. DO YOU USE TOBACCO IN ANY FORM
- 9. HOW MANY ALCOHOLIC DRINKS PER WEEK _____

FEMALES ONLY:

ARE YOU PREGNANT?
DATE OF LAST PERIOD: _____

EXPLAIN ALL "YES" ANSWERS: _____

WE PROVIDE YOU WITH A MEDICAL EXAMINATION PRIMARILY TO DETERMINE YOUR CAPACITY TO WORK SAFELY. ANY HEALTH PROBLEMS OR ANY CONDITION WHICH MAY BE OF CONCERN TO YOU MAY BE FREELY DISCUSSED WITH THE EXAMINING PHYSICIAN, THIS WAY YOU CAN CONTRIBUTE TO THE EFFECTIVENESS OF THE EXAMINATION. YOUR EXAMINATION, OF COURSE, IS A LIMITED ONE WHICH IS NEITHER DESIGNED TO SUBSTITUTE TREATMENT BY YOUR OWN PHYSICIAN OR THE PERIODIC EXAMINATIONS WHICH YOU WOULD OTHERWISE HAVE. TO A LARGE EXTENT THE EFFECTIVENESS OF THE EXAMINATION DEPENDS UPON THE COMPLETENESS OF THE MEDICAL HISTORY WHICH YOU GIVE IN THIS EXAMINATION.

I certify that my answers to the foregoing questions are correctly recorded and are true and I fully understand that any falsifications will be grounds for my dismissal of when such fact may be discovered by the company.

Date: _____

Signature of applicant: _____