Methodist Healthcare

HEALTH HISTORY

Social Security # _____ Date of Birth _____ Place of Birth _____Date_____

Name _____ Phone (home)_____ (cell) _____
LAST FIRST MIDDLE

Address _____ City _____ State _____ Zip Code _____

Department _____ Position _____

Have you had within the last year any of the following (<u>Check Every Item</u>):

	YES	NO		YES	NO
Allergies			Hearing Difficulties		
Asthma			High Blood Pressure		
Back Injury/Low Back Pain			Liver Disease or Jaundice		
Bleeding Problems			Numbness, Weakness or Fatigue		
Bone or Joint Problems			Palpitation, Pounding Heart		
Cancer, Cyst, Growth or Tumor			Reaction from Medicines		
Chest Pain or Pressure/Tightness			Rheumatism or Arthritis		
Chills, Fever, or Night Sweats			Rupture or Hernia		
Chronic Coughs or Colds			Shortness of Breath		
Coughing or Vomiting Blood			Shoulder, Arm or Hand Pain		
Diabetes			Skin Rash or Hives		
Diarrhea			Smoking Habit		
Emphysema			Vision Difficulties (Glaucoma or Cataract)		
Epilepsy/Convulsions			Weight Gain or Loss (Excessive)		
Fainting/Dizziness			Worry or Depression		
Headaches (Frequent or Severe)					

	YES	NO	
Are you currently receiving treatment or have you received treatment for alcohol or drug addiction within the last five years?			
Are you currently under a rehab agreement related to alcohol or drug addiction?			
Have you been hospitalized within the past three years?			
Have you had illnesses within the last three years other than those listed previously?			
Have you ever had any treatment for blood diseases?			
Have you ever filed a Worker's Compensation Claim or received benefits as a result of an industrial or occupational injury or disease? Have you lost time from work due to work related illnesses or injuries?			
Has your work been limited or restricted because of your health?			
Do you have any health conditions that would affect your ability to do the job you have been offered?			

The preceding statements are true and correct to the best of my knowledge, and it is understood that misrepresentation or omission of facts in this health history will be cause for rejection or dismissal if employed.

Agreement: (Please read before signing)
I hereby agree to authorize the release of any information deemed necessary from my medical records (physicians, hospitals or other institutions) to determine my qualifications for employment and/or work-related illness or injuries occurring during my employment at Methodist Le Bonheur Healthcare and agree to sign any required forms authorizing the release of such information.
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_____ _____
Signature Date

A. List all surgeries within the past three years. Include date if possible.

_____
_____
_____
_____

B. Allergies: Drugs _____
Chemicals or Cleaning Products _____
Latex (If "Yes" to Latex, Please Answer Questionnaire) _____
Other _____

C. Drugs Presently Taking:

_____
_____
_____

D. Are you or could you be pregnant? _____

E. In Emergency Notify: Name _____ Address _____ Phone _____

F. Personal Physician: Name _____ Address _____ Phone _____

To Be Completed By Associate Health Nurse

G. Age: _____ Height: _____ Weight: _____ BP: _____ Pulse: _____ Respiration: _____ Temp: _____

Color Vision: Passed _____ Failed _____ Visual Acuity: Passed _____ Failed _____ With Glasses or Contacts

H. Vaccinations: MMR x 2 _____ Tetanus _____ Tuberculosis Skin Test _____ Hepatitis A _____

Hepatitis B _____ Chicken Pox: Disease _____ Vaccine _____

MD STATEMENT(S) NEEDED BASED ON ASSESSMENT _____
_____
_____
_____

TBST

Date/Site _____ L R Forearm

Administered By _____

Lot/Exp Date _____

Result _____

Date Read _____

Read By _____

_____
Signature

Date/Site _____ L R Forearm

Administered By _____

Lot/Exp Date _____

Result _____

Date Read _____

Read By _____

_____
Date