

Please fill out completely
Central Maine Conditioning Clinic, Inc. – Health History Questionnaire

Date _____ Date of Birth _____ Sex: *Male* ___ *Female* ___

Name _____
Last First Middle Initial

Street Address _____ City _____ State: _____ Zip: _____

Phone (H) _____ (W) _____ (C) _____

Please complete the following information. This data is used to assist in **safe** job placement. The information will remain confidential and will not be a part of your personnel file. This information will be used only to determine your physical abilities as they relate to the safe performance of your job. If there are medical indicators that are contraindicated for us we will collect more information before recommending a job placement.

initial if read.

PLEASE CHECK ALL THE MEDICAL CONDITIONS THAT APPLY TO YOUR HEALTH HISTORY

	Yes	No	Explain/list for Other
Has a physician stated that you have any health condition that would limit or restrict your physical activity?			
Do you have ANY condition that limits your physical activity?			
Have you had a work/ or non occupational injury which placed restrictions on you at work?			
Are you currently in treatment for an injury/illness?			
Do you feel chest pain, have dizziness, lose your balance or lose consciousness when doing physical activity?			
Do you have any current or chronic orthopedic/musculoskeletal joint pain limitations?			
Has any healthcare professional ever placed any physical restrictions on your ability to lift? IF YES – WHO WHAT WEIGHT LIMIT? _____			
Do you know of any other reason why you should not do physical activity?			
*Are you pregnant or is there a chance that you may be pregnant?			

PLEASE LIST MEDICATIONS YOU TAKE AND IT'S PURPOSE. (INCLUDE OVER THE COUNTER AND ALLERGY REMEDIES)

Name	Purpose	Dosage
Name	Purpose	Dosage
Name	Purpose	Dosage

Look at the following activities and indicate as appropriate: Do you have pain/discomfort/difficulty with any of the following:

YES NO

1. Getting up from sitting or crouching.
2. Sitting for up to 2 hours.
3. Putting on footwear.
4. Vacuuming or sweeping the floor.
5. Typing or writing.
6. Using a shovel or rake.
7. Picking up small objects.
8. I can usually stand for 30 minutes.
9. I can lift 50 pounds from the ground to table top safely
10. I can twist or stretch without limitations or pain.
11. I do not have any hearing limitations.
12. My peripheral vision allows me to be safe.

Look at the following activities and indicate as appropriate: Do you have pain/discomfort/difficulty with any of the following:

Answer yes or no to the following statements: YES NO

13. I have had an injury that may interfere with my ability to perform this job safely.

14. I have increased pain when there is a change in the weather.

15. I drop things frequently.

16. I HAVE lifting restrictions.

If YES please list: _____

13. I usually bend at the knees when I pick items up off the floor.

14. I am in pain constantly.

15. I sometimes get pain when I perform certain activities.

If YES please list activity: _____

If YES please list body parts that have pain: _____

If YES circle your rating of the pain (1 is the least and 10 is the worst) 1 2 3 4 5 6 7 8 9 10

16. I am on medication for pain management.

If YES please list: _____

17. Is there a good physical reason not mentioned here why you should not perform any of the tasks listed above? Please list: _____

18. Do you smoke?

If NO, have you ever smoked? How much? _____ How many years? _____

If YES, how much? _____ How many years? _____

19. Do you use alcohol?

If YES, how much/how frequently? _____

20. Have you ever been treated for drug /Alcohol abuse?

Family Medical History: Have your parents, siblings or grandparents had any of the following:

- Arthritis
 - Blindness
 - Cancer
 - Tuberculosis
 - Diabetes
 - Deafness
 - High blood pressure
 - Sickle Cell Disease
 - Glaucoma
 - Psychological Illness
 - Heart Disease
 - Lung Disease
 - Long-Term Pain/Disability
 - Other _____ list
- 1st degree relative had a definite heart attack or stroke before age 55? (father/mother/brother/sister)

Check all that you have had or now have:

- Ear, nose, throat or sinus trouble
- Ringing in ears or difficulty hearing
- Back trouble, back pain, back injury
- Kidney, Bladder or urinary problems
- Heart trouble, heart attack
- High blood pressure
- Carpel Tunnel Syndrome
- Problems with circulation
- Depression
- Thrombophlebitis or blood clots
- Residual disability from polio
- Hay fever, hives or other allergies
- Parkinson's disease
- Convulsions/fits/dizzy/fainting spells
- Loss of sense of smell
- Eye trouble, eye injury or eye disease
- Arthritis, rheumatism, bursitis
- Broken or fractured bones
- Swelling of hands or feet
- Numbness, tingling in finger/hands
- Stroke
- Nervous or mental problems
- Heart or lung surgery
- Head injury or concussion
- Asthma
- Multiple sclerosis
- Bronchitis
- Pleurisy or fluid in lungs
- Broken eardrum
- Wear glasses or contact lenses
- Muscular dystrophy
- Dislocated or injured joints
- Rapid or irregular heartbeat
- Heart murmur
- Neck injury or whiplash
- Chest pain/angina
- Claustrophobia
- Varicose Veins
- Cerebral palsy
- Shortness of breath
- Skin trouble or dermatitis
- Cancer, cyst growth or tumor

- Pneumonia
- Frequent or persistent cough
- Persistent fatigue
- Other lung disease
- Bleeding tendency/easy bruising
- Chronic infection or immune system problems
- Gallbladder trouble
- High cholesterol
- Treatment for high cholesterol
- Other: Please describe: _____
- Anemia, blood problems, or blood disease
- Obstructive lung disease, emphysema
- Tuberculosis
- Gland disorder
- Ulcers
- Liver trouble, hepatitis
- Recent wt gain/loss
- Hernia, rupture
- Bowel trouble/change in bowel habit
- Hemorrhoids
- Night sweats
- Stomach or intestinal problem
- Diabetes
- Thyroid disease
- Abdominal pain
- Frequent headaches
- Chronic nausea or vomiting

List any doctor, chiropractor, or other health care person you have seen for evaluation and/or treatment in the past three years? Describe why:

- Doctor Reason _____
- Chiropractor Reason _____
- Other Reason _____

List all operations/hospitalizations including the years NONE

Operations: _____

Hospitalizations: (if any new on on-going medical problems, please list)

Please indicate yes in any area you have ever had any injury, pain, and swelling, discomfort, weakness, or any other problems shoulders arms wrists hands legs knees feet.

Check all that apply related to the position you are considering, have applied for, have been hired for or are currently in:

- Feel that I am physically able to do any work assignments I may be given.
- Feel that I am NOT able to physically handle any work assignments I may be given.
- Feel that I am able to physically handle some, but not all, of the work assignments I may be given
- Have a medical reason why I cannot work any shift assigned
- Have been told to avoid working in a noisy area.
- Have had heat stroke or had trouble working where it is hot.

Occupational History Check all that apply: Have you ever:

- Been able to work a dusty job
- Worked with laser or laser equipment
- Been unable to obtain or hold a job because of any allergy to dust, chemical, oils, etc?
- Been unable to do a particular work activity because of a physical or emotional disability?
- Been exposed to toxic gases, toxic dusts, or fumes? If yes, please list the names and dates(s) of exposure. _____
- Had to wear special safety equipment in past work (gloves, respirator, etc.) If yes, please describe any difficulties wearing the equipment _____

List previous jobs:

1.		
2.		
3.		
4.		
5.		

Statement of honesty:

I have truthfully answered the above questions to the best of my knowledge. I understand that withholding any relevant information or giving false information regarding the above can be cause for termination.

I have reviewed this form and agree that this is an accurate reflection of my current situation.

EMPLOYEE SIGNATURE

DATE

REVIEWER

DATE

For office use only:

NOTES: