MEDICAL HISTORY

The people who perform the pre-placement screens may or may not be physicians. This screen is for the company's purposes only and is not considered a medical examination. You should not and cannot rely upon this screen as an opinion as to your medical condition.

NAME:	**SOC SEC #:**
ADDRESS:	
HOME PHONE #:	
FAMILY PHYSICIAN NAME:	**PHONE #:**
DATE OF LAST PHYSICAL EXAM:	**DOCTOR:**
CRAFT:	**COMPANY:**

PERSONAL MEDICAL HISTORY: Do you now or have you ever had the following conditions?

(Answer every item individually by placing an X in the appropriate yes/no box below.)

Yes	No		Yes	No	
		Epilepsy			High Blood Pressure
		Seizures / Convulsions			Diabetes
		Stroke (Cerebral Vascular Accident)			Hemophilia (Free Bleeder)
		Parkinson's disease / Alzheimer's disease			Frequent nose bleeds
		Cerebral Palsy			Cancer or Tumor
		Multiple Sclerosis			Hodgkin's disease
		Residual disability from polio			Heavy Metal Poisoning
		Muscular Dystrophy			Ionizing Radiation Injury
		Mental Retardation			Confined Space fear (Claustrophobia)
		Psychoneurotic Disability (Mental Disability)			Fear of Heights
		Nervous Breakdown			Eye Trouble / Glasses / Contacts
		Fainting or Dizzy			Ear Trouble / Ear infections (L R)
		Vertigo			Deafness
		Headaches			Hearing difficulty
		Head Injury / (Mild Traumatic Brain Injury)			Ringing in ears
		Smoking - _____ packs/day			Hole in eardrum (L R)
		Alcohol Consumption _____ glasses/day			Cardiac Disease
		Hay Fever / Allergies			Hernia / Hernia Surgery
		Sensitivities to chemicals, dust, sunlight, allergens.			Jaundice
		Chest Pains			Kidney Trouble
		Heart attack / Myocardial infarction			Hemorrhoids
		Persistent Cough			Anemic Condition
		Bronchitis			Hyperinsulism (Too much insulin)
		Asthma			Skin Disorders
		Hoarseness			Rheumatism
		Pleurisy			Arthritis
		Pneumonia			Knee Problems
		Tuberculosis (TB)			Neck Problems
		Silicosis (Chronic Lung Disease)			Trick Shoulder, Elbow, Knee
		Frequent Colds / Sore Throat			Locking Knee Joint
		Arteriosclerosis (Hardening of Arteries)			Limitation of Movement
		Thrombophlebitis (Inflammation of vein in the legs			Ruptured Intervertebral Disc
		Varicose Veins / Spider Veins			Spinal fusion/ Surgical disc removal
		Compressed Air Sequelae (The Bends)			Chronic Bone Infection
		Vision loss or partial loss in one or both eyes			Ankylosis of Joints (Stiff Joints)
		Amputated foot, leg, arm, hand, or paralysis			Numbness of Body Part

Are you currently on any Medications? ☐ Yes ☐ No

If yes, what medications? _____

_____

LAST NAME		FIRST NAME
Yes	**No**	
		Do your feet/neck/back ever give you trouble when you walk or stand for long periods of time?
		Have you ever been a patient in a hospital or clinic?
		Were you ever in the hospital for nervous trouble?
		Have you ever been hospitalized, treated, or counseled for use of alcohol, drugs, or other chemicals?
		Have you ever been advised or do you contemplate having an operation?
		Have you ever had surgery?
		Has your weight changed more than 15 pounds in the last 2-4 months?
		Have you ever been refused employment because of your health?
		Have you ever received or do you have a current or pending claim for workmen's compensation?
		Have you ever had any injury or condition not mentioned on this form?

Are you currently pregnant? YES or NO

If yes how far along are you? _____

If yes when is your estimated delivery date? _____

How many months have you been absent from work in the last 5 years because of injury or illness to yourself? _____ Months

Have you ever had an injury illness, or condition that caused you to miss more than three (3) consecutive days?

Please describe? _____

When did you last consult a physician? (____/____/____) Why? _____

Your last X-Ray? (____/____/____) _____

Your last hearing test? (____/____/____) _____

REMARKS AND/OR EXPLANATIONS OF ANY YES ANSWERS OR TO CLARIFY ANY OF THE ABOVE:

_____

_____

_____

_____

_____

_____

PLEASE READ CAREFULLY BEFORE SIGNING:

I HAVE READ THE ABOVE AND DECLARE AND CERTIFY THAT ALL INFORMATION ON THIS FORM IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSIFICATION, MISREPRESENTATION, OR OMISSION REGARDING ANY OF THE ABOVE MAY BE USED AS THE BASIS FOR DISMISSAL AND WILL RESULT IN MY IMMEDIATE RELEASE FROM EMPLOYMENT.

FAILURE TO ANSWER INQUIRIES REGARDING WORKERS' COMPENSATION CLAIMS TRUTHFULLY MAY RESULT IN AN EMPLOYEE'S FORFEITURE OF WORKER'S COMPENSATION BENEFITS UNDER STATE LAW INCLUDING, WITHOUT LIMITATION, LOUISIANA STATUTE R.S. 23:1208.1.

_____ _____

Signature of Applicant Date

_____ _____

Physician Date

LAST NAME _____ FIRST NAME _____

Orthopedic History

1) Have you ever had any broken bones? ☐ Yes ☐ No

If yes, include month, year, and description of fracture.

/ -	/ -
/ -	/ -

2) Have you had any surgeries, including the neck, back, or any bone, joint or muscle? ☐ Yes ☐ No

If yes, include month, year, and description of surgery.

/ -	/ -
/ -	/ -
/ -	/ -

3) Do you *currently* have or have you *ever* sprained /strained / dislocated / or injured any of the following:

If yes, include month, year, description of injury, treating physician name, and phone number.

a) Head / Face	☐ No	☐ Yes	☐ Currently -	
b) Neck	☐ No	☐ Yes	☐ Currently -	
c) Shoulder	☐ No	☐ Yes	☐ Currently -	
d) Arm	☐ No	☐ Yes	☐ Currently -	
e) Elbow	☐ No	☐ Yes	☐ Currently -	
f) Forearm	☐ No	☐ Yes	☐ Currently -	
g) Wrist	☐ No	☐ Yes	☐ Currently -	
h) Hand	☐ No	☐ Yes	☐ Currently -	
i) Chest / Ribs	☐ No	☐ Yes	☐ Currently -	
j) Abdomen	☐ No	☐ Yes	☐ Currently -	
k) Groin	☐ No	☐ Yes	☐ Currently -	
l) Back	☐ No	☐ Yes	☐ Currently -	
m) Hip / SI	☐ No	☐ Yes	☐ Currently -	
n) Thigh	☐ No	☐ Yes	☐ Currently -	
o) Knee	☐ No	☐ Yes	☐ Currently -	
p) Shin / Calf	☐ No	☐ Yes	☐ Currently -	
q) Ankle	☐ No	☐ Yes	☐ Currently -	
r) Foot	☐ No	☐ Yes	☐ Currently -	

4) Have you had any other injuries that caused you to miss work? ☐ Yes ☐ No

If yes, please list.

/ -	/ -
/ -	/ -
/ -	/ -
/ -	/ -

5) Do you use any braces, supports, etc? ☐ Yes ☐ No

If yes, please list.
