Employee Health History

Name: _____D.O.B. _____ Phone #: _____

Position: _____ Dept/Office: _____ email:_____

Circle one: Employee Volunteer Contracted Employee Other _____

Medications: _____

_____

_____

Have you had in the past year:	Yes	No	Explain
Back Problems			
Other Musculoskeletal issues (knees, shoulders, hands, etc)			
Liver or Kidney problems			
Hospitalized in past year			
Cardiac Problems (heart, high BP, A-Fib, CHF, chest Pain)			
Skin disease or boils, abscesses			
Severe Allergies (needing to carry an Epi-Pen)			
Thyroid Problems			
Anxiety or Depression or other mental health concerns			
Pregnancy			
Anemia or blood disorders			
Asthma or other respiratory chronic illness			
Neurologic Conditions: (such as Epilepsy, Seizures, MS, ALS)			
Have you ever had any of the following in your lifetime:	**Yes**	**No**	**When (ie. current, 1978..)**
Tuberculosis or abnormal TB test			
Traumatic Brain injury			
Drug or Alcohol related problems			
Other: (Circle Correct Response)			
Are you a current tobacco user?	Yes	No	
Would you like assistance in quitting	Yes	No	Not Applicable

Have you missed 3 days or more in a row of work for illness/injury in the past 12 months? YES NO

If Yes, please explain: _____

Reviewed by: _____ _____ _____

(Provider Name) (Provider Signature) (Date Signed)