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ANNUAL HEALTH SURVEY

This Health Survey is a MEDTEAM ANNUAL REQUIREMENT and is intended to be a work-related assessment of my ability to perform without limitation. I certify that the answers to all survey questions are true and understand employment may be withdrawn or terminated due to misrepresentation, omission or falsification.

SINCE COMPLETING YOUR LAST HEALTH SURVEY HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

Alcohol abuse	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis C	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N	Smallpox	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Sprains	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Immune System disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Stomach Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N
Back strain	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Back surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Broken bones	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney stone	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N		
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Malaria	<input type="checkbox"/> Y <input type="checkbox"/> N		
Cardiovascular trouble	<input type="checkbox"/> Y <input type="checkbox"/> N	Mental condition	<input type="checkbox"/> Y <input type="checkbox"/> N		
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraine headaches	<input type="checkbox"/> Y <input type="checkbox"/> N		
Dislocation	<input type="checkbox"/> Y <input type="checkbox"/> N	Nervous condition	<input type="checkbox"/> Y <input type="checkbox"/> N		
Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N		
Fainting spells	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychological condition	<input type="checkbox"/> Y <input type="checkbox"/> N		
Hay fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N		
Hepatitis A	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N		
Hepatitis B	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N		

Please explain each yes answer.
 A separate sheet can be attached.

SINCE COMPLETING MY LAST HEALTH SURVEY, HAS ANY OF THE FOLLOWING INFORMATION CHANGED?

ALLERGIES	IMMUNIZATION	TB STATUS	PHYSICIAN DESIGNATION
Report known :	Tetanus ? <input type="checkbox"/> Vaccine <input type="checkbox"/> Booster	The date of my last PPD:	Name:
	Gamma Globulin ? <input type="checkbox"/> Y <input type="checkbox"/> N	Month: Year:	Address:
	Hepatitis B Immune Globulin <input type="checkbox"/> Y <input type="checkbox"/> N	My last CXR was performed:	
	Series completed ? <input type="checkbox"/> Y <input type="checkbox"/> N	Month: Year:	
	Date :		Telephone:

HEALTH CLEARANCE

The date of my last physical was ::Month:.....Year.....

The name and address of the physician and/or facility that performed the physical :

Name:

Address:.....City:.....State:.....Zip:.....

Telephone: []

Do you have any physical condition which might limit your ability to perform within your scope of duties? Yes No

Do you have any physical defects/limitation which precludes you from performing certain job/responsibilities? Yes No

Is there pending, or have you applied for a pension, or compensation for existing disability? Yes No

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