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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 I certify that the answers to all survey questions are true and understand employment may be withdrawn or terminated due to misrepresentation, omission or falsification.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.

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**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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