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**PRE-EMPLOYMENT HEALTH SURVEY**

This Health Survey is a MEDTEAM STAFFING PRE-EMPLOYMENT 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 that misrepresentation, omission or falsification may prevent an offer of employment, or if employment has been offered, to be withdrawn or terminated.

**EMERGENCY NOTIFICATION**

**Should I be involved in an accident or emergency situation, please notify:**

Last Name: \_\_\_\_\_ First Name : \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Telephone: [ \_\_\_\_\_ ] Business Telephone: [ \_\_\_\_\_ ]

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PHYSICIAN DESIGNATION**

**Should I be involved in an accident or emergency situation, please notify:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Telephone: [ \_\_\_\_\_ ] Business Telephone: [ \_\_\_\_\_ ]

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**HEALTH CLEARANCE**

**Should I be involved in an accident or emergency situation, please notify:**

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: [ \_\_\_\_\_ ]

**TB STATUS**

The date of my last PPD: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_ Performed where: \_\_\_\_\_

My last CXR was performed: Month: \_\_\_\_\_ Year: \_\_\_\_\_ Performed where: \_\_\_\_\_

**ALLERGIES (known allergy)**

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Latex	<input type="checkbox"/> Morphine, codeine, demerol or other narcotics/controlled
<input type="checkbox"/> Any food: Name _____		<input type="checkbox"/> Novocaine, xylocaine, or other anesthetics
<input type="checkbox"/> Alcohol preparations		<input type="checkbox"/> Penicillin or other antibiotics
<input type="checkbox"/> Aspirin, or other pain remedies		<input type="checkbox"/> Sulfa Drugs or medications
<input type="checkbox"/> Hay fever or seasonal allergies		<input type="checkbox"/> Tetanus antitoxin or other sera
<input type="checkbox"/> Iodine or other cleaning solutions		<input type="checkbox"/> Any other drug group or medication: Name _____

Do you have any physical condition which might limit your ability to perform the job for which you are applying? Yes  No

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

**ARE YOU NOW OR HAVE YOU EVER SOUGHT TREATMENT FOR**

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

HAVE YOU EVER BEEN	HAVE YOU EVER RECEIVED	DATE
Refused employment <input type="checkbox"/> Y <input type="checkbox"/> N	German Measles <input type="checkbox"/> Vaccine <input type="checkbox"/> Titer	
Unable to hold a position for health reasons <input type="checkbox"/> Y <input type="checkbox"/> N	Measles <input type="checkbox"/> Vaccine <input type="checkbox"/> Titer	
Unable to hold a position for medical reasons <input type="checkbox"/> Y <input type="checkbox"/> N	Mumps <input type="checkbox"/> Vaccine <input type="checkbox"/> Titer	
Unable to work due to health reasons <input type="checkbox"/> Y <input type="checkbox"/> N	Rubella <input type="checkbox"/> Vaccine <input type="checkbox"/> Titer	
Unable to work due to medical reasons <input type="checkbox"/> Y <input type="checkbox"/> N	Diphtheria <input type="checkbox"/> Vaccine <input type="checkbox"/> Titer	
Hospitalized in the last five years <input type="checkbox"/> Y <input type="checkbox"/> N	Pertussis <input type="checkbox"/> Vaccine <input type="checkbox"/> Titer	
Advised to have diagnostic tests that were not completed <input type="checkbox"/> Y <input type="checkbox"/> N	Small Pox <input type="checkbox"/> Vaccine <input type="checkbox"/> Titer	
Advised to have a hospitalization that was not completed <input type="checkbox"/> Y <input type="checkbox"/> N	BCG <input type="checkbox"/> Vaccine <input type="checkbox"/> Titer	
Advised to have a surgery which was not completed <input type="checkbox"/> Y <input type="checkbox"/> N	X-ray <input type="checkbox"/> Chest X-ray <input type="checkbox"/> Spine X-ray <input type="checkbox"/> Other	
	Tetanus <input type="checkbox"/> Vaccine <input type="checkbox"/> 10 year Booster	
	Steroids <input type="checkbox"/> Y <input type="checkbox"/> N	
Worked with cytotoxic drugs <input type="checkbox"/> Y <input type="checkbox"/> N	Gamma Globulin <input type="checkbox"/> Y <input type="checkbox"/> N	
Worked with radioactive materials <input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis B Immune Globulin <input type="checkbox"/> Y <input type="checkbox"/> N	
Had any serious illness in the last five years <input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis B Vaccine <input type="checkbox"/> Y <input type="checkbox"/> N	
Had your work restricted for health reasons <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 1 Date:	
Had a surgical procedure <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 2 Date:	
Procedure: _____ Date: _____	<input type="checkbox"/> 3 Date:	
Procedure: _____ Date: _____	Series completed: <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____	
Had treatment or consultation for musculoskeletal injury <input type="checkbox"/> Y <input type="checkbox"/> N	Is there pending, or have you applied for a pension, or compensation for any existing disability? <input type="checkbox"/> Y <input type="checkbox"/> N	
<b>Please explain each yes answer. A separate sheet can be attached.</b>		
Are you taking any medication or substance (prescription or otherwise) that may cause a positive result on a drug test? <input type="checkbox"/> Y <input type="checkbox"/> N		
If yes, please list all substances (i.e., the migraine medication Imitrex).		

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Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_