



Medical History Questionnaire

Please read carefully the following instructions for filling out this questionnaire. Complete and accurate forms will assist in your physical moving quicker and more efficient.

1. This questionnaire is a legal document.
2. The purpose of this questionnaire is to gather information concerning your health and physical condition, both current and past.
3. The information will be used only to determine whether you are in physically and mentally healthy enough to safely perform the duties of the position for why you are being considered.
4. You must answer all of the following questions as fully and completely as you can. To withhold or falsify information will result in immediate disqualification for the position in which you are applying.
5. **Each question must be answered individually:** please check mark each box. A continuous line or other indication that all answers are the same will not be accepted.
6. If you do not understand a question, or are unsure of how to answer please leave the question blank. The provider or other medical staff will provide clarification.

I agree that I have read and agree to the above instructions and will provide all the required information to the best of my ability.

Print Name: _____

Signature: _____

Date: _____



Medical History Questionnaire

100 E Cypress Ave, Redding, CA 96001
 Phone (530) 722-1111
 Fax (530) 722-9999

Name _____ Date of Birth _____ Age _____ Social Security No. _____ Date _____
 Address _____ City _____ State _____ Zip _____ Phone _____
 Job Title _____ Department _____ Division _____

The purpose of this questionnaire is to gather information concerning your health and physical condition, both current and past. This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered. Please answer all of the following questions as fully and completely as you can. If you do not understand a question, or are unsure of how to answer it, leave the question blank and medical professionals will assist you with clarification.

1. MEDICAL HISTORY
 a. Medical conditions

HEALTH CONDITION	NEVER HAD	PREVIOUSLY HAD	NOW HAVE	DON'T KNOW	HEALTH CONDITION	NEVER HAD	PREVIOUSLY HAD	NOW HAVE	DON'T KNOW
HEAD, NOSE, MOUTH & THROAT					GASTROINTESTINAL SYSTEM				
Persistent or severe headaches					Persistent or severe nausea or indigestion				
Frequent nose bleeds					Persistent or severe stomach pain				
Frequent nasal congestion					Vomiting blood				
Persistent/severe sinus condition					Persistent or severe vomiting				
Bleeding gums					Hernia (<i>rupture</i>)				
Persistent/Severe dental condition					Stomach or duodenal ulcer				
Hoarse when don't have cold					Colitis				
Difficulty swallowing					Hemorrhoids or piles				
Persistent sore throat					Change in bowel habits				
Loss of taste or smell					Black stool				
Other head, nose, mouth or throat condition Please list:					Blood in stool				
EARS AND HEARING					Persistent or severe constipation				
Hearing difficulties					Persistent or severe diarrhea				
Use hearing aids					Pancreatitis				
Ringing in ears (<i>tinnitus</i>)					Other conditions of stomach or intestines Please list:				
Perforated ear drum					LIVER, SPLEEN & GALLBLADDER				
Persistent or severe ear infection					Cirrhosis				
Other ear or hearing conditions Please list:					Hepatitis				
EYES AND VISION					Jaundice				
Glaucoma					Gallstones				
Cataract					Other conditions of liver, spleen or gallbladder Please list:				
Eye infection					KIDNEYS AND URINARY TRACT				
Defective vision					Kidney stones				
Color blindness					Kidney infection				
Injury to the eye					Blood in urine				
Eye surgery					Pain or burning when urinating				
Double vision					Frequent urination				
Glasses					Albumen or protein in urine				
Contact lenses					Prostate condition				
Other eye or vision conditions Please list:					Burning/discharge from penis (male only)				
RESPIRATORY SYSTEM					Other conditions of kidneys or urinary tract Please list:				
Persistent or severe colds/cough					REPRODUCTIVE SYSTEM (<i>females only</i>)				
Coughing blood					Breast lumps				
Asthma or wheezing					Breast discharge				
Emphysema					Reached menopause				
Pneumonia					Irregular periods				
Tuberculosis					Bleeding between periods				
Other respiratory system conditions Please list:					Excessive bleeding during menstruation				
CARDIOVASCULAR SYSTEM					Significant change in periods				
Heart attack					Hysterectomy				
Stroke					Pregnancy				
Hardening of the arteries					Difficulty becoming pregnant				
High blood pressure					REPRODUCTIVE SYSTEM (<i>male and female</i>)				
Heart murmur					Sterilization (<i>vasectomy, tubal ligation, etc.</i>)				
Palpitations or irregular heart beat					Diagnosed infertility problems				
Episodes of chest pain or tightness					Change in sexual ability				
Shortness of breath					Other reproductive system conditions Please list:				
Varicose veins									
Swelling of ankles, feet or legs									
Other cardiovascular system conditions Please list:									

Name _____

1. MEDICAL HISTORY (continued)

a. Medical History (continued)

HEALTH CONDITION	NEVER HAD	PREVIOUSLY HAD	NOW HAVE	DON'T KNOW	HEALTH CONDITION	NEVER HAD	PREVIOUSLY HAD	NOW HAVE	DON'T KNOW			
NEUROLOGICAL SYSTEM					SKIN							
Epilepsy, convulsions, seizures					Dermatitis or eczema							
Periods of blackouts/loss of consciousness					Hives							
Fainting spells					Moles that bleed or get larger							
Dizzy spells (vertigo)					Change in color of skin (other than suntan)							
Memory difficulty					Frequent boils/abscesses							
Tremor of the hands or head					Acne							
Paralysis of any type					Trouble with fingernails							
Persistent of severe numbness, tingling, weakness. If so list body part affected					Small itching blisters on the sides of your fingers or palms of hands							
Other neurological conditions Please list:					Sores that do not heal							
PSYCHOLOGICAL/MOOD					ALLERGIES (caused by)							
Mental condition requiring hospitalization					Food							
Suicidal thoughts or attempts					Soaps and/or detergents							
Desired/sought psychological help					Metals, chromium							
Drug, narcotic or alcohol dependency					Nickel							
Persistent or severe depression/worry					Rubber							
Persistent or severe difficulty sleeping					Epoxy resin							
Other psychological conditions Please list:					Plants (e.g., poison ivy, etc.)							
MUSCULOSKELETAL					INFECTIOUS OR CHILDHOOD DISEASES							
Arthritis					Meningitis/encephalitis							
Swollen or painful joints					Polio							
Bursitis or tendinitis					Rheumatic fever							
Back pain					Mumps							
Back surgery					Measles							
"Trick" or lock knee					Venereal disease							
Knee surgery					MEDICATION HISTORY							
Painful or "trick" shoulder					MEIDCATION NAME		Now taking		Taken in last year		Allergic to	
Chiropractic treatments						Yes	No	Yes	No	Yes	Unsure	
Persistent or severe muscle aches or pains If so where:					Anesthetics (e.g., Novocain)							
Other musculoskeletal conditions Please list:					Antacids							
ENDOCRINE/METABOLIC SYSTEM					IMMUNIZATION STATUS							
Diabetes					TEST OR IMMUNIZATION FOR:		EVER RECEIVED?			LAST RECEIVED		
Thyroid condition or disease						YES	NO	DON'T KNOW	YEAR	DON'T KNOW		
Hypoglycemia					Gamma globulin							
Unexplained weight gain					Hepatitis B							
Unexplained weight loss					Influenza							
Gout					Polio							
Osteoporosis or other bone disease					Rubella (measles)							
Other condition of the endocrine system Please list:					Smallpox							
BLOOD/LYMPH SYSTEM					MEDICATION HISTORY							
Anemia					MEIDCATION NAME		Now taking		Taken in last year		Allergic to	
Bleeding disorder						Yes	No	Yes	No	Yes	Unsure	
Sickle cell disease or trait					Anticoagulants							
Phlebitis/blood clotting disorder					Arthritis medicines							
Blood transfusion					Aspirin or aspirin substitutes							
Chills, fever or night sweats					Asthma medicines							
Swelling of lymph nodes that doesn't go away					Birth control pills							
Other blood or lymph conditions Please list:					Blood pressure medicine							
IMMUNIZATION STATUS					MEDICATION HISTORY							
TEST OR IMMUNIZATION FOR:		EVER RECEIVED?			LAST RECEIVED		Now taking		Taken in last year		Allergic to	
		YES	NO	DON'T KNOW	YEAR	DON'T KNOW		Yes	No	Yes	Unsure	
Gamma globulin												
Hepatitis B												
Influenza												
Polio												
Rubella (measles)												
Smallpox												
Tetanus												
TB test												
Other immunization or tests Please list:												
ENDOCRINE/METABOLIC SYSTEM					MEDICATION HISTORY							
Diabetes					MEIDCATION NAME		Now taking		Taken in last year		Allergic to	
Thyroid condition or disease						Yes	No	Yes	No	Yes	Unsure	
Hypoglycemia					Anesthetics (e.g., Novocain)							
Unexplained weight gain					Antacids							
Unexplained weight loss					Anticoagulants							
Gout					Arthritis medicines							
Osteoporosis or other bone disease					Aspirin or aspirin substitutes							
Other condition of the endocrine system Please list:					Asthma medicines							
BLOOD/LYMPH SYSTEM					MEDICATION HISTORY							
Anemia					MEIDCATION NAME		Now taking		Taken in last year		Allergic to	
Bleeding disorder						Yes	No	Yes	No	Yes	Unsure	
Sickle cell disease or trait					Anticoagulants							
Phlebitis/blood clotting disorder					Arthritis medicines							
Blood transfusion					Aspirin or aspirin substitutes							
Chills, fever or night sweats					Asthma medicines							
Swelling of lymph nodes that doesn't go away					Birth control pills							
Other blood or lymph conditions Please list:					Blood pressure medicine							
IMMUNIZATION STATUS					MEDICATION HISTORY							
TEST OR IMMUNIZATION FOR:		EVER RECEIVED?			LAST RECEIVED		Now taking		Taken in last year		Allergic to	
		YES	NO	DON'T KNOW	YEAR	DON'T KNOW		Yes	No	Yes	Unsure	
Gamma globulin												
Hepatitis B												
Influenza												
Polio												
Rubella (measles)												
Smallpox												
Tetanus												
TB test												
Other immunization or tests Please list:												

Name _____

1. MEDICAL HISTORY (Continued)

b. Surgical History

1. Have you ever had surgery? yes No
if yes,

	TYPE OF SURGERY	YEAR	NAME OF SURGEON	LOCATION OF HOSPITAL	COMPLICATIONS, IF ANY
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

c. Hospitalization History

1. Have you ever been hospitalized? yes no

If yes, complete the following information about hospitalization.

	PART OF BODY AFFECTED	NATURE OF ILLNESS OR REASON FOR HOSPITALIZATION	DATE (MO/YR)	WORK RELATED? Y/N	IF YES, EMPLOYER NAME
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

d. OTHER

1. Have you ever been denied life or health insurance or offered it only at additional rates? yes no
2. Have you ever been denied employment for health reasons? yes no
3. Have you ever been disqualified for entry into or discharged from the Armed Services for medical reasons? yes no
4. Have you ever received, is there pending, have you applied for or do you intend to apply for a pension or compensation? yes no
5. Have you ever had to change jobs for health reasons? yes no
6. Do you currently have any health condition that may limit your performance of any type of task or job? yes no
7. Are you currently partially disabled or impaired in any way other than corrected vision? yes no
8. Are you currently under treatment or observation for any physical or mental health condition? yes no
9. Have you ever received disability compensation from the Armed Services? yes no
10. Have you ever received a disability retirement from a civilian job? yes no

If any of the above questions were answered yes please explain:

Name _____

2. FAMILY HISTORY

HEALTH CONDITION OR DISEASE	TYPE OF RELATIVE															
	Mother		Father		Paternal Grandmother		Maternal Grandmother		Paternal Grandfather		Maternal Grandfather		Brothers or Sisters		Natural Children (born alive)	
	Died of	History of	Died of	History of	Died of	History of	Died of	History of	Died of	History of	Died of	History of	Died of	History of	Died of	History of
1. Heart attack or heart disease																
2. High blood pressure																
3. Stroke																
4. Lung disease or respiratory condition																
5. Asthma																
6. Tuberculosis																
7. Severe loss of hearing before age 50																
8. Glaucoma																
9. Diabetes																
10. Thyroid disease or condition																
11. Ulcers or other stomach and intestinal condition																
12. Liver or gallbladder disease/condition																
13. Kidney disease/condition																
14. Convulsions/epilepsy																
15. Blood or lymph disease or condition																
16. Rheumatism/arthritis																
17. Mental condition, nervous breakdown, suicide																
18. Serious accident																
19. Cancer																
20. Age now or at death																

3. SOCIAL HISTORY

- Do you smoke cigarettes? yes no
- Have you ever smoked cigarettes in the past? yes no
- If you now smoke, or have smoked in the past, how many years total have you smoked? _____ years
- If you now smoke, or have smoked in the past how many packs per day do/did you smoke on average? (Choose the closest answer)
 - Less than one-half (1/2) One (1) One and one-half (1 1/2) Two (2)
 - Two and one-half (2 1/2) Three (3) More than three (3+)
- Do you regularly drink alcoholic beverages? yes no
- If yes, how many drinks, beers or glasses of wine do you drink daily?
 - Less than 1 1-2 3-4
 - 5-6 7-8 More than 8
- Do you exercise strenuously for at least 30 minutes:
 - Daily Three times a week once a week
 - Rarely Never
- Do you feel frustrated, stressed or uptight?
 - Daily Three times a week once a week
 - Rarely Never
- Do you eat fatty or greasy foods?
 - Daily Three times a week once a week
 - Rarely Never

Name _____

