

Post-Offer Medical Questionnaire

(To be maintained in a separate file of confidential medical records)

\*\*\*\*\*\* If there is any question or statement on this form you do not understand, \*\*\*\*\*\*

ask for assistance from the person interviewing you.

Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security (last four digits only) # \_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By completing this form, I am verifying the company has already presented a conditional job offer to me. \_\_\_\_\_ Initial

The presence of one or more impairments does not automatically render you unfit as an employee. All decisions will be made on job-related criteria. Reasonable accommodation will be made if appropriate, provided it does not pose an undue hardship upon the company making the conditional job offer.

## Please Complete the Following Medical Information

 **Have You Ever Had?** **Have You Ever Had?**

 Yes No Asthma Yes No Hay fever

 Yes No Migraine headaches Yes No Diabetes

 Yes No A head injury Yes No Color blindness

 Yes No A fear of heights Yes No An amputated foot, leg, arm, or hand

 Yes No Heart trouble Yes No Loss of sight of one or both eyes

 Yes No Fainting spells or dizziness Yes No Injury to your shoulder(s)

 Yes No Swelling of the legs or ankles Yes No Multiple sclerosis

 Yes No Skin rashes or Eczema Yes No Parkinson’s disease

 Yes No Joint pains or Arthritis Yes No Cardiovascular disorder

 Yes No Epilepsy Yes No Tuberculosis

 Yes No Cancer Yes No Mental retardation

 Yes No Varicose veins Yes No Hemophilia

 Yes No Sickle cell anemia Yes No Chronic infection of bone

 Yes No Tendonitis Yes No Muscular dystrophy

 Yes No Repetitive Motion Disorder Yes No Ruptured disc

 Yes No Stiffness of major weight-bearing joints Yes No Nervous trouble or treatment

 Yes No Kidney Problems Yes No Depression

 Yes No Injury to your knee(s) Yes No Injury to your Neck

 Yes No Injury to your lower back Yes No Injury to your wrist/hands

 Yes No Do you have partial loss of hearing?

Yes No Have you ever had an audiogram (hearing test)? If yes, results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you need glasses to read or for distance?

 Yes No Any serious wrist problems including Carpal Tunnel Syndrome?

 Yes No Any broken bones? Which bones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No High blood pressure? If yes, do you take medication to control high blood pressure? Yes No

 Yes No Any serious injuries? Month \_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_ Nature of the injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No A hernia or rupture? Month \_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_

 Yes No Any neck pain or problems? Month \_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_

 Yes No Injured back? Month \_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_

 Yes No Surgery? Month \_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_ Type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No Ever refused surgery? Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have You Ever Had?**

 Yes No An allergic reaction to any drugs? Which drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No Partial loss of uncorrected vision of more than 75 percent bilaterally?

 Yes No Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution

 for a period in excess of six months?

 Yes No Any permanent condition that constitutes 20 percent impairment of a foot, leg, hand, or arm, or of

 the body as a whole?

 Yes No Have you participated in recreational drug use within the past year?

 Yes No Have you ever participated in a drug abuse treatment program?

 Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No Do you currently take any prescription medications? If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No Do you have any condition or have you sustained any injury that would have an effect on your capacity to

 perform the duties of this position without reasonable accommodations?

Estimate the number of workdays you have lost in each of the past two years. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the name of any doctors you have seen during the past two years.

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Please provide pertinent facts to every previous ailment or injury contributing to impairment.

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**Have You Ever Been Treated For?**

 Yes No Back pain Yes No Neck pain

 Yes No Hand pain Yes No Mental conditions

**Have You Ever Been Refused Employment or Unable to Hold a Job Because of?**

 Yes No Sensitivity to dust Yes No Inability to perform certain motions

 Yes No Inability to assume certain positions Yes No Other medical reasons? Please Specify below.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*Our Workers’ Compensation Insurance carrier may check for previous claims by name and social security number. If you had a previous claim or injury, and fail to make us aware of it, you may be denied workers’ compensation benefits in the event of a new injury. For your own protection, please complete this form accurately.\*\*\* \_\_\_\_\_\_\_ *Initials*

By signing below, the employee is certifying the accuracy of his/her statements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Representative Date