NAME:

MEDICAL HISTORY

PLEASE COMPLETE THE FOLLOWING PRIOR TO SEEING PROVIDER - LEAVE NO BLANK SPACES:

	YES	NO	DON'T KNOW
Frequent Headaches			
Eye or Ear Infections			
Throat Trouble			
Sinus Trouble			
Thyroid Problems			
Frequent Colds			
Lumps or Tumors in Neck			
Asthma			
Pneumonia			
Pleurisy			
Spitting up Blood			
Coughing up Blood			
Chronic Cough			
Lung Trouble			
Tuberculosis			
Shortness of Breath			
Chest Pains			
Rheumatic Fever			
Heart Murmur			
Swelling of Ankles			
Low Blood Pressure			
Stomach Trouble			
Heartburn			
Vomiting Blood			
Black Bowel Movements			
Blood in Stools			
Frequent Diarrhea			
Abdominal Pains			
Gallbladder Trouble			
Liver Trouble			
Hepatitis or Jaundice			
Piles, Hemorrhoids			
Tropical Disease or Worms			
Hernia or Rupture			
Kidney Trouble			
Kidney Stones			
Blood in Urine			

	YES	NO	DON'T KNOW
Bladder Infections			
Frequent Urination			
Broken Bones			
Back Sprains or Surgery			
Arthritis			
Deformities of Joints			
Deformities of Bones			
Missing Fingers or Toes			
Ruptured Disc in Back			
Skin Rashes			
Skin Tumors			
Head Injury			
Epilepsy or Fits			
Frequent Dizziness			
Paralysis			
Loss of Memory			
Diabetes or High Sugar			
Sugar in Urine			
Allergies			
Allergic reaction to food			
Allergic reaction to Drugs			
Anemia			
Polio			
Recent Weight Loss			
Recent Weight Gain			
Fatigue			
Depression			
Anxiety or Panic Attacks			
Change in Activity Level			
High Blood Pressure			
Chronic Bronchitis			
Muscle Pain			
Sleeping Problems			
Breast Lumps			
Loss of Consciousness			
Excessive Thirst			

NAME:

Have you ever:	YES	NO
1. Suffered from hearing problems or hearing loss		
2. Suffered from visual problems or eye diseases		
3. Had back problems, back pain or back injuries		
4. Had foot problems		

Have you ever been a patient in a hospital for any reason? YES NO
If YES, please complete the following section:

	NAME OF HOSPITAL	CONDITION TREATED FOR	DATES
1			
2			
3			
4			
5			
6			
7			
8			

Have you ever lost time from work in the past year for ANY REASON? YES NO
If YES, Please explain: _____

Are you currently uder the treatment or care of a physician, Nurse Practitioner or other health care provider in the past year?
If YES, Please explain: _____

Do you SMOKE? YES NO
If YES - What do you smoke?_____ How many per day?_____ How many years?
_____

Do you drink ALCOHOL? YES NO
If YES - How many drinks do you drink at each sitting?_____ How many days per week?_____
What do you drink? BEER WINE HARD LIQUOR OTHER:_____

Are you taking prescribed or over the counter medications, herbal products, vitamins or supplements?

MALES ONLY:
Have you now or have you ever had a HERNIA or RUPTURE OF A HERNIA? YES NO
Have you ever had problems with your testicles (surgery, infection, injury)? YES NO

FEMALES ONLY:
Have you now or have you ever had any problems with your breasts (lumps, tumors, surgery)? YES NO
Are you now or have you ever been pregnant? YES NO If YES, how many pregnancies?_____
Miscarriages?_____ Are your periods regular? YES NO Do you have pain with your periods? YES NO
Date of Last Period_____

NAME:

VACCINATION HISTORY:

Last known Tuberculin Skin Test? _____ Results: Negative Positive - If positive was a Chest X ray done? YES NO

Last Tetanus Shot_____

If YES - Results of Chest x ray?_____

Hepatitis B Vaccination YES NO If YES, when?_____

What is your private healthcare providers name? _____

Address: _____

Phone number: _____

I give permission to the screening healthcare provider at Prime Staff Health to forward any abnormal findings to my healthcare provider. I understand that I am responsible for following up with my own healthcare provider on any abnormal findings that arise during the pre-employment physical conducted by the healthcare screening provider at Prime Staff Health. I understand that Prime Staff Health will not provide follow-up treatment for such findings.

PRINT NAME SIGNATURE DATE

The information contained in this form is of a strictly confidential nature. The form may be seen only by the examining healthcare provider, nurses in attendance and administrative personnel reviewing the chart for quality assurance reasons. I hereby declare the answers I have given are to the best of my knowledge.

PRINT NAME SIGNATURE DATE