

EMPLOYEE HEALTH EXAMINATION RECORD

Name _____ Date _____

Family Physician _____ DOB _____

Put an X on the line if you have had any of the following:

Diabetes _____ Operations _____ Please list _____

Fractures _____ _____

Head Injury _____ _____

Back Injury _____ _____

Chronic back pain _____ Other injuries-Please list _____

Tuberculosis _____ _____

Heart trouble _____ _____

Stomach trouble _____ _____

Fainting spells _____ _____

Epilepsy _____ Any other chronic health problems _____

Mental disease _____

Jaundice _____

Rheumatism _____

Asthma _____

Hernia _____

I have read the above and declare that I have had no injury, illness or ailment than as specifically herein noted. Any falsification or misrepresentation will be sufficient grounds for release from employment.

Signature _____
(employee)