POST EMPLOYMENT HEALTH QUESTIONNAIRE

Name _____ **Social Security No.** _____

Address _____ **City** _____

State _____ **Zip** _____ **Phone No** _____

Emergency Contact: _____

Emergency Contact Phone No _____

A detailed Medical Health Questionnaire is required to learn everything possible about your general health. This information is also required in determining Second Injury Fund eligibility.

*** Family Physician and Address:** _____

_____

*** Date of last medical treatment:** _____

*** Are you regularly taking medication? Yes ☐ No ☐**

If yes, please list _____

_____

_____

*** Surgeries, Injuries and Accidents.**

-Have you ever had any type of surgical operation(s)? Yes ☐ No ☐

If yes, please list each operation, date, treating doctor, and date of last treatment.

_____

_____

_____

-Have you ever had an injury or accident requiring medical attention? Yes ☐ No ☐

If yes list date, treating doctor, and date of last treatment.

_____

_____

_____

*** Illness Hospitalization**

-Have you ever had any illnesses requiring medial attention? Yes ☐ No ☐

If yes, list each illness, date, treating doctor, and the date of last treatment.

_____

_____

-Have you ever had any mental treatment? Yes ☐ No ☐

If yes, list each illness, date, treating doctor, and the date of last treatment.

_____

-Have you ever been hospitalized, other than what is listed above? Yes ☐ No ☐

If yes, list reason, date, treating doctor, and date of last treatment.

* Allergies:

-Do you have an allergy to any medicine? Yes ☐ No ☐

If yes, list each one

-Do you have an allergy to other things such as foods, pollen, chemicals, etc.? Yes ☐ No ☐

If yes, list each one, what caused it and the year.

* Are you under doctor's care at the present time? Yes ☐ No ☐

If yes, explain

* Have you ever received radiation exposure for the medical treatment, worked with X-ray, radioactive interior asbestos o silicosis? Yes ☐ No ☐

If yes, please explain.

* Have you worked in a dusty trade such as mining, foundry work, blasting, smelting, chemical industries, or textile industries? Yes ☐ No ☐

If yes, please explain.

* Have you ever had any ill effects from the type of work you have done? Yes ☐ No ☐

If yes, please explain.

* Has you work ever been limited or restricted due to your health, accident or injury? Yes ☐ No ☐

If yes, please explain.

* Have you ever filed for worker's comp. or received benefits as a result of an industrial injury or disease? Yes ☐ No ☐

If yes, please explain.

* Have you ever been confined to bed or home due to illness or injury? Yes ☐ No ☐

If yes, give approximate number of days lost from work and explain.

* **Is there any type of work you cannot perform because of your health? Yes ☐ No ☐**

If yes, please explain. _____

_____

* **Have you ever received a pension or benefits from physical disability? Yes ☐ No ☐**

If yes, please explain. _____

_____

* **Have you ever used any type of drugs in your lifetime? Yes ☐ No ☐**

If yes, please explain. _____

_____

* **Have you ever been a patient for mental illness? Yes ☐ No ☐**

18. Has any doctor ever treated you in your lifetime for drug usage? Yes ☐ No ☐

If yes, please explain. _____

_____

* **Have you ever been treated for carpal tunnel? Yes ☐ No ☐**

If yes, please explain. _____

_____

* **Have you ever been treated for ganglion cysts? Yes ☐ No ☐**

If yes, please explain. _____

_____

* **Do you have or have you ever been treated for any of the following conditions?**

	Yes	No		Yes	No
Heart Trouble	☐	☐	**Lung Problems**	☐	☐
Arthritis	☐	☐	**Emphysema**	☐	☐
Skin Rash	☐	☐	**Dizziness**	☐	☐
Diabetes	☐	☐	**Rheumatism**	☐	☐
Chest Pain	☐	☐	**Broken Bones**	☐	☐
High Blood Pressure	☐	☐	**Bone Disease**	☐	☐
Ulcer	☐	☐	**Hernia**	☐	☐
Bursitis	☐	☐	**Epilepsy**	☐	☐
Tuberculosis	☐	☐	**Varicose Veins**	☐	☐
Chicken Pox	☐	☐	**Dermatitis**	☐	☐

* **Have you ever had problems with your back? Yes ☐ No ☐**

If yes, please complete the following:

-List all problems & date _____

-Doctor(s) who treated you _____

-Employer at the time of treatment: _____

* **Have you ever had any problems with your arms or hands? Yes ☐ No ☐**

If yes, please complete the following:

-List all problems & date _____

-Doctor(s) who treated you _____

-Employer at the time of treatment: _____

* **Have you ever had any problems with your legs, knees, ankles, or toes? Yes ☐ No ☐**

If yes, please complete the following:

-List all problems & date _____

-Doctor(s) who treated you _____

-Employer at the time of treatment: _____

* **Have you ever had any problem with your neck or shoulders? Yes ☐ No ☐**

If yes, please complete the following:

-Who was your employer at the time _____

-Dates of all accidents: _____

-How did the accidents occur? _____

-Explain each accident: _____

-In which state did the accident occur? _____

I understand that my employment with Source Logistics, Inc. is contingent upon successful completion of a health review and receipt of a health clearance.

Signature _____ **Date** _____

Social Security Number _____