Post-offer, Pre-placement Health Questionnaire

Name _____SSN _____ Date _____

Address _____ City _____zip _____ phone _____

Date of birth _____ Position applied for, (job) _____

Have you ever been seen at Occupational Health Services before? □Yes □ No If yes, when_____

Have you ever been **hospitalized** or had **surgery**? □Yes □ No. If yes, please give the reason and approximate date:_____

Do you now, or have you ever, had any of the following:

1)	Broken bones	□Yes □ No
2)	Dislocations	□Yes □ No
3)	Swollen joints	□Yes □ No
4)	Foot, leg, or hip pain or injury	□Yes □ No
5)	Knee pain or injury	□Yes □ No
6)	Neck pain, injury, or disk disease	□Yes □ No
7)	Back pain, injury, or disk disease	□Yes □ No
8)	Chiropractic treatment	□Yes □ No
9)	Shoulder pain or injury	□Yes □ No
10)	Elbow or arm pain or injury	□Yes □ No
11)	Wrist or hand pain or injury	□Yes □ No
12)	Tendonitis	□Yes □ No
13)	Carpal Tunnel Syndrome	□Yes □ No
14)	Tuberculosis	□Yes □ No
15)	Asthma or lung disease	□Yes □ No
16)	Heart or circulatory problems	□Yes □ No
17)	High blood pressure	□Yes □ No
18)	Diabetes	□Yes □ No
19)	Hepatitis or jaundice	□Yes □ No
20)	Cancer or tumors	□Yes □ No
21)	Blood disorder	□Yes □ No
22)	Mental or emotional illness	□Yes □ No
23)	Severe or frequent headaches	□Yes □ No
24)	Ulcers, digestive or stomach problems	□Yes □ No
25)	Skin problems	□Yes □ No
26)	Seizures or epilepsy	□Yes □ No
27)	Serious allergies	□Yes □ No
28)	Are you taking any medications	□Yes □ No

If yes, please list the medications

Do you smoke? □Yes □ No
If yes, how much? _____/ day

Do you drink alcohol? □Yes □ No
If yes, how much? _____/ week

Do you exercise? □Yes □ No
If yes, what type _____

WOMEN ONLY:
Date of last menstruation _____
Do you have problems with menstruation that cause you to lose time from work? □Yes □ No

Have you ever been released from employment or the armed services because of a medical condition? □Yes □ No

Have you ever been refused employment or insurance because of a medical condition? □Yes □ No

Have you received temporary or permanent disability for a work-related injury or work-related illness? □Yes □ No

Do you have any physical limitations that will affect your ability to perform the duties of the position that you have applied for? □Yes □ No

Occupational Health Services
Sonoma Valley Hospital
347 Andrieux St. Sonoma, CA 95476
Phone 707-935-5470 7775_12.3/Rev 04/17/08

Over

Have you ever had a tuberculosis (T.B.) skin test? □Yes □ No. If Yes, when? _____

What were the results of the test?

□ Negative (no reaction to the test, or only a small amount of redness.)

□ Positive, (a red lump).

If you have had a positive reaction, did you have a **chest x-ray**? □Yes □ No

If Yes, what were the results? _____

Note: A past reaction to a TB test means that you should **not** have another one. A chest x-ray will be ordered, instead, if a TB test is required for the job.

In your own words, please give a brief explanation to all the YES answers, from page 1.
(Please give the **approximate date**, type of treatment received and state whether or not you still have pain or problems from the injury or condition)

I understand that any deliberate omission or deletion of medical history can result in my discharge from employment or not being hired. I certify that I have provided as accurate and complete information as I am able.

Signature _____ Date _____

Privacy statement:

The information on this questionnaire will be used to help determine your fitness for the position you have applied for. The employer will only be informed of conditions that impact the performance of job duties, place limitations on the job duties, or affect your health and safety or the safety of others, during the performance of the job.

Signature _____ Date _____

Examiner's comments: