

MEDICAL QUESTIONNAIRE

(To be completed after an offer of employment is extended.)

Name of employer _____

Name of employee _____

Employee's Social Security no. _____ Height _____ Weight _____

1. Do you now have, or have you ever had, any of the following?

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (convulsions, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	Surgical or spontaneous fusion of a major weight-bearing joint (frozen joint)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (medication? <input type="checkbox"/> Yes <input type="checkbox"/> No)	<input type="checkbox"/>	<input type="checkbox"/>	Hyperinsulinism
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac (heart) disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Meniscectomy (inflammation of cartilage of certain joints—e.g., knee)	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Amputation of foot, leg, arm or hand	<input type="checkbox"/>	<input type="checkbox"/>	Herniated intervertebral disk
<input type="checkbox"/>	<input type="checkbox"/>	Total loss of sight of one or both eyes, or a partial loss of corrected vision of more than 75% bilaterally	<input type="checkbox"/>	<input type="checkbox"/>	Surgical removal of an intervertebral disk, or spinal fusion
<input type="checkbox"/>	<input type="checkbox"/>	Polio (poliomyelitis)	<input type="checkbox"/>	<input type="checkbox"/>	Total deafness
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	One or more back or neck injuries or a disease process of the back or neck, substantiated by a doctor's opinion and resulting in disability over a total of 120 or more days
<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Obesity (30% overweight)
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Patellectomy (surgically removed kneecap)			_____
<input type="checkbox"/>	<input type="checkbox"/>	Ruptured cruciate ligament (knee ligament)			_____
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia			_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic osteomyelitis (infection in bone)			_____

2. Have you previously received workers' compensation for an on-the-job injury? Yes No *If yes, please write why, when and where.**

3. Have you ever received a disability rating or had one assigned to you by an insurance company or state/federal agency? Yes No *If yes, state percentage: _____%.*

4. Have you ever injured or sprained your back? Yes No *If yes, did you have surgery?* Yes No *If yes, please give details.**

5. Have you ever injured or sprained your neck? Yes No *If yes, did you have surgery?* Yes No *If yes, please give details.**

6. Have you ever injured or sprained a knee? Yes No *If yes, did you have surgery?* Yes No *If yes, please give details.**

7. Have you ever had any other type of surgery not mentioned above? Yes No *If yes, please give details.**

8. Do you have arthritis? Yes No *If yes, what parts of the body are affected?** _____
 Are you on medication for arthritis? Yes No

The information on this form shall not be used to discriminate against a qualified individual with a disability because of the existence of the disability in regard to the following: job application procedures; hiring, advancement or discharge of the employee; employee compensation; job training; and other terms, conditions and privileges of employment.

Under penalty of perjury, I declare that I have read the foregoing and that the facts alleged are true to the best of my knowledge and belief.

Employee's signature _____ Date _____

Employer's signature _____ Position _____ Date _____