School Board of Brevard County
MEDICAL HISTORY QUESTIONNAIRE

*(For applicants who have received conditional job offers. The statement as found on this page must be signed by the applicant **BEFORE** completing the following Medical Questionnaire)*

Date position was offered by school or department | Name of Supervisor/Principal/Director *(please print)* | Supervisor/Principal/Director (*signature*)

I herewithin affirm that the employer has made me an offer of employment, conditioned on the satisfactory completion of this questionnaire and, if necessary, within the sole discretion of the employer, a medical examination. The purpose of this inquiry is to determine whether I currently have the physical and mental qualifications necessary to perform the job which has been conditionally offered, whether and what accommodations may be necessary, and whether I can perform such job without posing a direct threat to the health or safety of myself or others, and for the other purposes and reasons as stated on this questionnaire.

It is the policy of Brevard Public Schools that protected health information may not be used or disclosed except when: consent is given, the information is used for treatment, payment or other health care operations are required, those involved in the health care of the individual so require, compliance related issues exist or required by law or other public purposes. The information on this form will be kept confidential in a separate medical file, apart from my personnel file. I herewith affirm that the questions as found in this medical questionnaire have not been asked of me by anyone with the employer until after I have signed this statement and been conditionally offered a job.

Applicant Name *(please print)* | Social Security Number | Signature

STATE OF FLORIDA
COUNTYOF
SWORN TO AND SUBSCRIBED TO before me on this _____ day of _____ , 20____

(SEAL)

NOTARY PUBLIC
My Commission expires:_____

Date Human Resources gave school/ department authority to hire | Human Resources Rep offering position (*please print*) | Human Resources Rep (*signature*)

1. Have you ever had or been treated for any of the following conditions or diseases.

YES	NO		YES	NO	
☐	☐	Epilepsy	☐	☐	Any permanent physical condition which constitutes a greater than one percent (1%) impairment of a member or of the body as a whole
☐	☐	Diabetes	☐	☐	Rheumatic fever
☐	☐	Cardiac Disease (heart trouble)	☐	☐	Chest pain
☐	☐	Amputation of foot, leg, arm or hand	☐	☐	High blood pressure
☐	☐	Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75 percent bilaterally.	☐	☐	Varicose veins or leg ulcer
☐	☐	Residual disability from poliomyelitis (polio)	☐	☐	Tuberculosis
☐	☐	Cerebral palsy	☐	☐	Allergies
☐	☐	Multiple sclerosis	☐	☐	Hay fever or Asthma
☐	☐	Parkinson's disease	☐	☐	Skin trouble
☐	☐	Hemophilia	☐	☐	Reaction to serum or drug
☐	☐	Chronic osteomyelitis (bone infraction)	☐	☐	Kidney or bladder trouble
☐	☐	Hyperinsulinism (low blood sugar)	☐	☐	Ulcers
☐	☐	Muscular dystrophy	☐	☐	Head injury
☐	☐	Thrombophlebitis (inflammation of a vein with a blood clot formed in the vein)	☐	☐	Cancer
☐	☐	Herniated, ruptured or bulging disk	☐	☐	Dizziness or fainting spells
☐	☐	Surgical removal of an intervertebral disk or spinal fusion	☐	☐	Arthritis or rheumatism
☐	☐	Surgery anywhere on the spinal column - starting from your neck to the top of your buttocks	☐	☐	Knee injury
☐	☐	Total deafness	☐	☐	Backache
☐	☐	Mental retardation	☐	☐	Shoulder or rotator cuff injury
☐	☐	Meniscectomy, Patellectomy or other knee surgeries	☐	☐	Alcoholism
☐	☐	Ruptured or torn cruciate ligament	☐	☐	Drug addiction
☐	☐	Surgical or spontaneous fusion of a major weight bearing joint	☐	☐	Severe headaches
☐	☐	One or more back injuries or diseased process of the back resulting in disability over a total of 30 or more days.	☐	☐	Chronic cough
☐	☐	Prior industrial accidents with the school board or any other employer	☐	☐	Shortness of breath
☐	☐	Are you receiving Social Security Disability benefits	☐	☐	Nervous breakdown
			☐	☐	Mental illness, psychiatric treatment or professional counseling
			☐	☐	Marie-Strumpell Disease

2. **Please list any condition or diseases for which you have been treated in the past 3 years. If no treatment has been provided, state "none".**

3. **Have you ever been hospitalized? If so, for what condition? If you have not been hospitalized, state "none".**

4. **Have you ever been, or are you being treated by a psychiatrist or psychologist? If so, for what condition? If no such treatment has been received, state "none".**

5. **Have you ever been, or are you being treated for any mental condition? If no such treatment has been received, state "none".**

6. **Are there any health-related reasons, physical, mental or emotional, that might indicate you are not able to perform the job for which you are applying? If yes, please explain. If none, state "none".**

7. **Have you had a major illness in the last 5 years? If none, state "none".**

8. **How many days were you absent from work because of illness last year? If none, state "none".**

9. **Do you have any physical impairments or limitations which preclude you from performing certain kinds of work? If yes, describe such impairments or limitations and specific work limitations resulting there from. If none, state "none".**

10. **Do you have any disabilities or impairments which may affect your performance in the position for which you are applying? If yes, please explain. If none, state "none".**

11. **Are you taking any prescribed drugs? If yes, state the name of the medication and the reason for taking it. If no medications are being taken, state "none".**

12. **Have you ever been, or are you being, treated for drug addiction or alcoholism? If yes, identify the medical care provider and dates of treatment. If no treatment has been provided, state "none".**

13. **Have you ever been, or are you being, treated by a physician that has given you permanent physical limitations? If so, indicate the name of the treating physician and what part of the body was treated. List the numerical rating, assigned by your physician (if any) and describe the limitations assigned (i.e. push, pull, lifting). If you had no such treatment, state "none".**

14. **Have you ever filed a workers' compensation claim? *(Yes or No)* If yes, list the date of the accident, company name where this occurred and part of body injured. List all prior workers' compensation claims.**