HEALTH HISTORY SCREEN

Independent Contractor Name: _____

Date: _____

Address: _____

Phone (Home): _____ Date of Birth: _____

Height: _____ Weight: _____ Weight Last Year: _____

Drug Allergies: _____

Date of Last Physical Exam: _____ Physician's Name: _____

Current Medications: _____

Current Medical History: (Check if you are currently experiencing any of the following problems)

_____ Shakes/Tremors
_____ Sweating
_____ Difficulty Breathing
_____ Irregular Menstrual Cycle
_____ Constipation
_____ Diabetes
_____ Skin Problems
_____ Nausea/Vomiting
_____ Anemia/ Blood Disorders
_____ Dental Problems
_____ Bleeding Easily
_____ Diarrhea
_____ Fatigue
_____ Venereal Disease
_____ High Blood Pressure
_____ Loss of Appetite
_____ Difficulty Walking
_____ Ear or Hearing Problems
_____ Heart Problems
_____ Weight Problems
_____ Eye or Sight Problems
_____ Other _____

Habits:

Smoke: Packs Daily: _____ How Long: _____ When Stopped: _____

Exercise Routine: _____ Coffee (cups daily): _____

Alcohol Usage Pattern: _____.

Sleep Pattern: _____

Hospitalizations or Surgeries: _____
(Reason, Date)

HEALTH HISTORY

Check if you have ever experienced any of the following medical problems. If checked, when and are you currently under the care of a physician?

_____ Chronic Headache
_____ Pneumonia
_____ Rheumatic Fever
_____ Shortness of Breath
_____ Scarlet Fever
_____ Measles
_____ Heart Palpitation
_____ Gall Bladder/GI
_____ Heart Murmur
_____ Sexual/Menstrual
_____ Depression
_____ Chest Pain
_____ Nervousness
_____ Frequent Infections
_____ Asthma
_____ Chronic Rashes
_____ Mumps
_____ Back problems
_____ Bronchitis
_____ Allergies/Hay Fever
_____ Arthritis
_____ Vascular Disease
_____ Ulcer
_____ Hepatitis
_____ S.T.D.
_____ Dizziness/Fainting

Have you ever been exposed to or have a history of TB? ___Yes ___No

If Yes, please explain: _____

Have you ever had a positive TB test result? ___ Yes ___No

If Yes, please explain: _____

Do you have any concerns about your health? ___ Yes ___No

If Yes, please explain: _____

Have you filed a Workman Compensation Claim? ___Yes ___No

If Yes, please explain: _____

The above information is true and completed to the best of my ability.

Signature: _____ Date: _____
Independent Contractor

Reviewed by:

Human Resources - Signature:_____ Date: _____

Staff RN - Signature:_____ Date: _____