

# Employee Health Assessment Form



## EMPLOYEE DATA

Name (print last, first, middle)	SS#	Birth Date	Phone
Address	City	State	Zip
Emergency Contact & Number	Relationship		
Department	Position	Sex (M, F)	Marital Status (S, M, W, D)
Personal Physician & Number			

## FAMILY HEALTH HISTORY

Has a family member (parents, siblings, grandparents) had any of the conditions listed? Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_

Heart Disease \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Tuberculosis \_\_\_\_\_

## PERSONAL HEALTH HISTORY

	Yes	No		Yes	No		Yes	No
Back Injuries	{ }	{ }	Heart Disease	{ }	{ }	Permanent defect from illness, disease, injury	{ }	{ }
Seizures, fainting, dizziness	{ }	{ }	Stomach Ulcer	{ }	{ }		Stomach, gall bladder trouble	{ }
Any type allergies	{ }	{ }	Rheumatic fever	{ }	{ }	Smoker (amount)	{ }	{ }
Tuberculosis	{ }	{ }	Hearing difficulty	{ }	{ }	Drink alcohol (amount)	{ }	{ }
Any type Hepatitis, jaundice	{ }	{ }	Kidney disease	{ }	{ }	Ever injured on the job	{ }	{ }
Nervous disorder	{ }	{ }	Muscular disease	{ }	{ }	Women-pregnant at this time	{ }	{ }
Respiratory disease	{ }	{ }	Mental illness	{ }	{ }	Incapacitated by pain during period	{ }	{ }
High Blood Pressure	{ }	{ }	Hernia	{ }	{ }	Vision difficulty, eye disease	{ }	{ }
Arthritis, gout, joint disease	{ }	{ }	Diabetes	{ }	{ }	Ear, nose, throat trouble-sinus, colds	{ }	{ }
Cancer	{ }	{ }	Headaches	{ }	{ }	Receiving medical treatment at the present time or in the past 6 months	{ }	{ }
						Ever been turned down for life insurance, military service, or employment for physical reasons	{ }	{ }

If answer to any of the above is yes, explain:

\_\_\_\_\_

Medication Allergies \_\_\_\_\_

Medications Now Taking \_\_\_\_\_

Last Tetanus Vaccination: \_\_\_\_\_

Childhood diseases:	Had	Immunized	Did not have, not immunized, appropriately instructed
Chicken pox	{ }	{ }	{ }
Red Measles (Rubeola)	{ }	{ }	{ }
Mumps	{ }	{ }	{ }
German Measles (Rubella)	{ }	{ }	{ }

Would you say your present health is { } Excellent { } Good { } Fair { } Poor

MEN date last prostate exam and results \_\_\_\_\_

WOMEN date last PAP smear and results \_\_\_\_\_

I hereby authorize the release of this information and the results of any physical examination and health history to management of Avenue Home Care, Inc. for the purpose of evaluating any need of accommodation. This information is true and correct to the best of my knowledge.

Signature of Applicant \_\_\_\_\_

## TO BE COMPLETED AT ORIENTATION BY EMPLOYEE HEALTH RN

Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Height \_\_ft \_\_in Weight \_\_\_\_\_

Summary/remarks possible limitations and/or need for accommodation or need for further examinations to determine the need for accommodations:

\_\_\_\_\_

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_