HCFB Health History/Release Form

I understand that I will be given a physical examination and be asked to complete a medical questionnaire. I hereby authorize and release my medical examiner to provide the results of the physical examination, a medical questionnaire and any other information obtained about me to: _____ for any use they deem appropriate.
(Name of Employer)

I have read and understand the job description and essential functions of the position I have applied for and feel I am physically capable of performing all essential tasks.

Date: _____ Employee Signature:

_____

Name:

_____

Date of Birth: _____ SSN:

_____

Address:_____

City: _____ State: _____ Zip:

_____

Job Being Evaluated for:

_____

Occupational History (please check)

Have you ever worked with:	Yes	No	Have you ever:	Yes	No
Toxic Chemicals			Been unable to hold a job because of a medical condition?		
Asbestos			Worked in a noisy environment?		
Lead			Been refused employment for health reasons?		
Dust, Smoke, Gases			Been refused life insurance because of your health?		
Have you had a recent TB test? If yes, date: / /			Had an industrial or workers' compensation injury that caused you to be out of work?		

Please explain any "yes" responses:

Medical History - Part I

Have you ever:	Yes	No	If yes, please explain and give dates
Been seriously ill or injured?			

Had any operations?			
Had any broken bones?			

Are you currently taking any medications? Yes _____ No _____. If yes, please explain.

Medical History-Part II

Do you now have or did you ever have any of the following conditions? (Give dates)

	Yes	No		Yes	No		Yes	No
Frequent or severe headaches			High blood pressure			Arthritis		
Vision difficulties			Unexplained weight change			Carpal tunnel		
Eye injuries or defect			Digestive disorder			Tendinitis		
Glaucoma or cataracts			Recurring abdominal pain			Gout		
Hearing difficulties			Colon or bowel disease			Varicose veins		
Ear abnormalities			Liver disease			Foot problems		
Sinus problems			Gallbladder problems			Skin rash or eczema		
Goiter or thyroid problems			Kidney or bladder stones			Sleep Apnea		
Frequent or chronic cough			Hemorrhoid/Rectal disease			Seasonal Allergies		
Asthma			Kidney or bladder disease			Allergies to drugs		
Bronchitis			Hemorrhoid/Rectal disease			Diabetes		
Pneumonia			Hernia			Anemia		
Tuberculosis			Head Injury			Bleeding disorder		
Other lung disease			Dizziness or fainting spells			Blood clots		
Shortness of breath			Epilepsy/ convulsions			Cancer		
Chest pain or pressure			Nervous disorder			Mononucleosis		
Palpitation or pounding heart			Paralysis			Measles		
Heart Disease			Neck injury			German measles		
Heart Attack (When?)			Back injury			Mumps		
Heart Murmur			Other Neck/back injury			Chicken pox		

Please explain any "yes" responses or any other illness/injury

Medical History-Part II (continued)

Smoking History

Amount:

_____

Duration:

_____

Alcohol Intake

Amount:

_____

Duration:

_____

Immunizations (if applicable)

☐ Measles (date _____)_____

☐ German Measles (date _____)_

☐ Mumps (date _____)

☐ Hepatitis B Vaccine (date _____)_____

☐ Tetanus (date _____)

☐ Diphtheria (date _____)_

The preceding statements are true to the best of my knowledge and I understand this will become part of my employee medical record. I understand that an incorrect statement is ground for release.

_____

_____ _____

Signature of Applicant Date