



Work Comp Associates, Inc.

Florida's Premier Source for Workers' Compensation Coverage & Information

Medical History Questionnaire

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Instructions to follow.

This form is provided courtesy of Work Comp Associates, Inc.

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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)

I herewith 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 or mental qualifications necessary to perform the job that has been offered, whether and what accommodations may be necessary, and whether I can perform the job without posing a direct threat to the health or safety of myself or others and for the purposes and reasons as stated on the attached questionnaire.

This information will be kept confidential in a separate medical file, apart from my personnel file. I herewith affirm that the questions as found in the attached medical questionnaire have not been asked of me by anyone with the employer until after have signed this statement and been offered a job.

I understand that this questionnaire is considered in an "active" status only for a period of thirty (30) days. If I am not employed by the employer during this period of time, I must re-submit a new medical history questionnaire if there is a continued desire to be hired by the employer.

I understand that all information contained in this questionnaire will be checked or otherwise confirmed by the employer and I herewith specifically give the employer authorization to contact my prior employers and other sources of information regarding my background. In addition thereto, I hereby authorize any prior employer or reference or other source of information to answer any questions concerning my prior employment. I hereby agree to hold any employer, including the employer from whom medical history questionnaire is herewith made, or other source of information harmless of any claim arising from this authorization to provide information. I further understand that the employer may conduct a consumer report investigation on my background and if such is conducted, I may submit a written request to the employer for a complete copy of the requested information. I hereby release the employer and any firm performing the consumer investigation of any and all liability from any damage that may result from the investigation, use, or disclosure of such information.

I understand further that any misstatements or omissions in this questionnaire will result in a decision not to hire me or if employed to thereafter terminate my employment.

Name: _____

Social Security Number: _____

Signature: _____

WITNESS

WITNESS

STATE OF FLORIDA

COUNTY OF _____

SWORN TO AND SUBSCRIBED TO before me on this _____ day of
_____, 20____.

(SEAL)

NOTARY PUBLIC
My Commission expires:

MEDICAL HISTORY QUESTIONNAIRE

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

	Yes	No
Epilepsy	_____	_____
Diabetes	_____	_____
Cardiac disease (heart trouble)	_____	_____
Amputation of foot, leg, arm or hand	_____	_____
Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally	_____	_____
Residual disability from poliomyelitis	_____	_____
Cerebral palsy	_____	_____
Multiple sclerosis	_____	_____
Parkinson's disease	_____	_____
Hemophilia	_____	_____
Chronic osteomyelitis (bone infection)	_____	_____
Hyperinsulinism (low blood sugar)	_____	_____
Muscular dystrophy	_____	_____
Thrombophlebitis (inflammation of a vein with a blood clot formed in the vein)	_____	_____
Herniated intervertebral disk (slipped disk)	_____	_____
Surgical removal of an intervertebral disk or spinal fusion	_____	_____
Total deafness	_____	_____
Mental retardation	_____	_____
Meniscectomy	_____	_____
Patellectomy	_____	_____
Ruptured Cruciate Ligament	_____	_____
Surgical or Spontaneous Fusion of a major weight bearing joint	_____	_____
One or more back injuries or diseased process of the back resulting in disability over a total of 120 or more days	_____	_____
Prior industrial accidents with this company or affiliated company	_____	_____
Any permanent physical condition which constitutes a 20 percent impairment of a member or of the body as a whole	_____	_____
Rheumatic fever	_____	_____
High blood pressure	_____	_____
Varicose veins or leg ulcer	_____	_____
Chest pain	_____	_____
Tuberculosis	_____	_____
Allergies	_____	_____
Hay fever or Asthma	_____	_____
Skin trouble	_____	_____

MEDICAL HISTORY QUESTIONNAIRE

	Yes	No
Reaction to serum or drug	_____	_____
Kidney or bladder trouble	_____	_____
Ulcers	_____	_____
Head injury	_____	_____
Cancer	_____	_____
Dizziness or fainting spells	_____	_____
Arthritis or rheumatism	_____	_____
Knee injury	_____	_____
Backache	_____	_____
Shoulder injury	_____	_____
Alcoholism	_____	_____
Drug addiction	_____	_____
Severe headaches	_____	_____
Chronic cough	_____	_____
Shortness of breath	_____	_____
Nervous breakdown	_____	_____
Mental illness, psychiatric treatment or professional counseling	_____	_____

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 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 treated for any mental condition? If no such treatment has been received, state "none."

MEDICAL HISTORY QUESTIONNAIRE

6. Is there any health-related reason you may not be able to perform the job for which you are applying? If yes, please explain.

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 defects which preclude you from performing certain kinds of work? If yes, describe such defects and specific work limitations. 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?

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

12. Have you ever been 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."

MEDICAL HISTORY QUESTIONNAIRE

13. Have you ever filed for workers' compensation insurance?

Witness

Applicant for Employment

Witness