EMPLOYEE HEALTH HISTORY

Name____ **D.O.B.** _____________
Last **First**

ADDRESS ____ **PHONE NUMBER** ______________________

FAMILY PHYSICIAN ____________________________________ **PHONE NUMBER** ______________________

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

____ **PHONE NUMBER**________________________
Last **First**

<u>HEALTH HISTORY:</u>

ACCIDENTS – (Serious) ____ **DATE** ______________________

ALLERGIES (Pollens, drugs, foods) ____ **ASTHMA** ______________

DIETARY RESTRICTIONS: ____

VEGETARIAN? _____ **YES** _____ **NO**

BLOOD TYPE _______________ **UNKNOWN** __________________ **EARACHES** ___________________

CONVULSIVE DISORDER _____ **DIABETES** ___________________ **HEADACHES** _________________

EYE PROBLEM _____________ **FAINTING SPELLS** ____________ **CRAMPS** _____________________

FREQUENT COLDS ________ **HERNIA** ______________________ **KIDNEY DISEASE** _____________

HEART CONDITION _______ **HIGH BLOOD PRESSURE** ______

INOCULATIONS: DATE OF SERIES OF TETANUS TOXOID AND/OR BOOSTER __________________________

____

OPERATIONS – (serious) + dates ____

____

ORTHOPEDIC DEFECTS____

RHEUMATIC FEVER ____

ARE YOU A POSITIVE TUBERCULIN REACTOR YES ( ) NO ( )

LIST ANY OTHER HEALTH PROBLEMS YOU MAY HAVE: ____

____

____

LIST ANY MEDICATIONS PRESENTLY PRESCRIBED: ____

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____ _______________________________
Signature of Employee **Date**