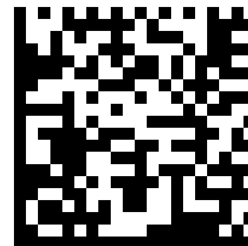

Employee Health Assessment

☐ Annual Assessment ☐ Pre-Employment

Name:

Condition – Indicate Illness Experienced by You or Your Family					
Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Mental Illness	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Epilepsy / Convulsions	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Other:		

TB Screen	Have you experienced the following symptom's?				
Chest Pain	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Lingering Cold	☐ Yes	☐ No	Chest Pain / Pressure in Chest	☐ Yes	☐ No
Loss of Energy	☐ Yes	☐ No	Swelling in Legs and Feet	☐ Yes	☐ No
Weight Loss + 15 lbs in past year	☐ Yes	☐ No	Pain in Calf when Walking	☐ Yes	☐ No
Blood in Sputum	☐ Yes	☐ No	Change in Bowel Habits	☐ Yes	☐ No
Increased Sweating at Night	☐ Yes	☐ No			
Migraine Headaches	☐ Yes	☐ No	Back Pain	☐ Yes	☐ No
Fainting or Dizziness	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Weight Gain/Loss 15 lbs	☐ Yes	☐ No	Pain when Urinating / Blood in Urine	☐ Yes	☐ No
Change in Energy Level	☐ Yes	☐ No	Infectious Disease	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No	Increased Thirst	☐ Yes	☐ No
Blood in Sputum	☐ Yes	☐ No	Persistent Sores or Lumps	☐ Yes	☐ No

Do you smoke? ☐ Yes ☐ No If yes how much?

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes how much?

Do you take depressant, stimulant, narcotic drugs that altar your behavior? ☐ Yes ☐ No

Do you take prescription medications? ☐ Yes ☐ No Which Medicine?

Physician Info.

Name of Physician:

Address: Phone #:

I have read the above and declare that I have no injury, illness or ailment other than as specifically identified. I certify that I am not habituated to any depressants, stimulants, narcotics, drugs, alcohol, or other substances that may alter my behavior.

Signature:

x: Date: