MEDICAL HISTORY FORM

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NAME	
SOCIAL SECURITY NUMBER	
JOB TITLE	

Do you or have you had (check each item)	N	Y	YEAR
Psychiatric Problem			
Heart Disease			
Diabetes			
Neurological Disorder			
Back/ Neck History of Problems			
Shoulder, Wrist, Elbow Problems			
Other			

Do you have any health conditions or work restrictions that would prevent you from performing the essential functions of the job to which you have been assigned.

N	Y

If yes, explain:

Are you currently taking medication for any reason?

N	Y

If yes, explain:

I certify that the above information is complete to the best of my knowledge and that I understand that any falsification will be cause for dismissal.

Signature: _____ Date: _____