

Post Hiring Medical Questionnaire

Welcome to our company! This questionnaire is solely for the purpose of providing us with information so that we will have access to the Subsequent Injury Trust Fund in appropriate cases. The questionnaire is not being used as the basis for deciding whether to employ you.

Name: _____

Height: _____ **Weight:** _____ **Social Security #:** _____

Drivers License #: _____ **Telephone #:** (706) _____

Instructions: Circle YES or NO to the following questions. If you answer YES, list the approximate date of injury or treatment and give the details (doctor, hospital, etc.) in the space for details after the last questions. Be sure to number your responses if you answered YES to more than one question. Do not use checkmarks. Do not skip any question.

1. Have you ever had a back injury? YES or NO If so, when?
2. Have you ever had a herniated intervertebral disc in your back? YES or NO If so, when?
3. Have you ever had back surgery for removal of a disc? YES or NO If so, when?
4. Have you ever had a neck injury? YES or NO If so, when?
5. Have you ever had a herniated disc in your neck? YES or NO If so, when?
6. Have you ever had neck surgery for removal of a disc? YES or NO If so, when?
7. Have you ever had a knee injury? YES or NO If so, when? Which knee?
8. Have you ever had surgery on either of your knees? YES or NO If so, when? Which knee?
9. Have you ever had surgery on either of your shoulders? YES or NO If so, when? Which shoulder?
10. Have you ever had an elbow injury? YES or NO If so, when? Which elbow?
11. Have you ever had surgery on either elbow? YES or NO If so, when? Which elbow?
12. Have you every had an amputation of your foot, leg, arm, or hand? YES or NO If so, when?
13. Do you have or have you ever had epilepsy? YES or NO If so, when?
14. Do you have or have you ever had diabetes? YES or NO If so, when?
15. Do you have or have you ever had cardiac disease (heart trouble)? YES or NO If so, when?
16. Do you have or have you ever had Marie-Strumpell disease? YES or NO If so, when?
17. Do you have or have you ever had total loss of sight of one of both eyes or a partial loss of corrected vision of more than 75 percent bilaterally? YES or NO If so, when?
18. Do you have or have you ever had residual disability from poliomyelitis? YES or NO If so, when?
19. Do you have or have you ever had cerebral palsy? YES or NO If so, when?
20. Do you have or have you ever had multiple sclerosis? YES or NO If so, when?
21. Do you have or have you ever had Parkinson's disease? YES or NO If so, when?
22. Do you have or have you ever had vascular disorder? YES or NO If so, when?
23. Do you have or have you ever had psychoneurotic disability following treatment in a recognized medical/mental institution for a period in excess of 6 months? YES or NO If so, when?
24. Do you have or have you ever had hemophilia? YES or NO If so, when?
25. Do you or have you ever had chronic osteomyelitis? YES or NO If so, when?

26. Do you or have you ever had ankylosis of a major weight-bearing joint? YES or NO If so, when?
27. Do you have or have you ever had hyperinsulinism? YES or NO If so, when?
28. Do you have or have you ever had muscular dystrophy? YES or NO If so, when?
29. Do you or have you ever had thrombophlebitis? YES or NO If so, when?
30. Do you have or have you ever had loss of hearing? YES or NO If so, when?
31. Do you have or have you ever had Mental Retardation? YES or NO If so, when?
32. Do you have or have you ever had any physical or mental condition in which you believe to be permanent? YES or NO If so, briefly describe condition.
33. Are you now or have you ever been obese? (30% more over normal body weight) YES or NO If so, when?
34. Do you have or have you ever had rheumatic fever? YES or NO If so, when?
35. Do you have or have you ever had high blood pressure? YES or NO If so, when?
36. Do you have or have you ever had varicose veins or leg ulcer? YES or NO If so, when?
37. Do you have or have you ever had tuberculosis? YES or NO If so, when?
38. Do you have or have you ever had allergies or asthma? YES or NO If so, when?
39. Do you have or have you ever had skin trouble? YES or NO If so, when?
40. Do you have or have you ever had reaction to serum or drugs? YES or NO If so, when?
41. Do you have or have you ever had kidney or bladder trouble? YES or NO If so, when?
42. Do you have or have you ever had ulcers? YES or NO If so, when?
43. Do you have or have you ever had a head injury? YES or NO If so, when?
44. Do you have or have you ever had cancer? YES or NO If so, when?
45. Do you have or have you ever had arthritis or rheumatism? YES or NO If so, when and where?
46. Do you have or have you ever had sickle cell anemia? YES or NO If so, when?
47. Have you ever been ruptured? (hernia) YES or NO If so, when? Which side?
48. Do you have or have you ever had carpal tunnel syndrome? YES or NO If so, when? Which wrist?
49. Have you ever had any injury, operation or any disability not covered by the above questions? YES or NO Is so, when?
50. Is there any question that you do not understand? YES or NO Which question?
Space for details:

All statements and information given in this application are true, to the best of my knowledge and belief.

Name of Applicant (printed) _____

Name of Applicant (Signed) _____

TO BE COMPLETED BY THE EMPLOYER

REVIEWED BY: _____

TITLE: _____ DATE: _____