OhioHealth

ASSOCIATE HEALTH AND WELLNESS

ASSESSMENT DATE _____

HEALTH HISTORY

NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH
STREET ADDRESS	SSN#
CITY, STATE, ZIP	PHONE
EMERGENCY CONTACT	PHONE

PERSONAL HISTORY AND REVIEW OF SYSTEMS: X if yes.

PERSONAL HISTORY:		(continue comments, if any)		ANXIETY/NERVOUSNESS	
MEASLES				NUMBNESS	
GERMAN MEASLES				SMOKING	
MUMPS				# PACKS A DAY	
CHICKEN POX				UNUSUAL FATIGUE	
WHOOPING COUGH				UNUSUAL WEAKNESS	
EPILEPSY		REVIEW OF SYSTEMS:		UNABLE TO SLEEP	
BONE OR JOINT DISEASE		FREQUENT HEADACHES		SKIN TROUBLE	
ARTHRITIS		BLURRY VISION		BACK PAIN	
JAUNDICE		EYE PAIN		LATEX ALLERGY	
TUBERCULOSIS		HEARING LOSS		BROKEN BONES	
DIABETES		FREQUENT INFECTIONS		HEAD INJURIES	
CANCER		RINGING IN EARS		BLOOD	
HIGH OR LOW BLOOD PRESSURE		CHRONIC COUGH		SURGERY (If YES, LIST)	
ASTHMA		COUGHING BLOOD		1.	
HIVES/RASHES		SHORTNESS OF BREATH		2.	
STROKE		CHEST PAIN		3.	
HEART ATTACK		SWOLLEN ANKLES		4.	
LIVER DISEASE		IRREGULAR HEART BEAT		HOSPITALIZATION (IF YES, LIST)	
KIDNEY DISEASE		LOSS OF APPETITE		1.	
HERNIA		TROUBLE SWALLOWING		2.	
ALCOHOL/DRUG PROBLEM (IF YES, COMMENT)		NAUSEA OR VOMITING		3.	
		ABDOMINAL PAIN		ALLERGIES (If YES, LIST)	
		FAINTING SPELLS		1.	
		DIZZINESS		2.	
		TREMORS		3.	

List all Medications presently taking including non-prescription drugs and herbal remedies(optional)

1.	3.	5.	7.
2.	4.	6.	8.

Do you have any limitations that would keep you from performing the duties of your job? □ No □ Yes, if yes explain.

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_____

Are there any accommodations that you need our company to make to perform this job? □ No □ Yes, if yes explain.

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Any other information that might be useful? □ No □ Yes, if yes explain.

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(for office use only)

Reviewed by:_____Date:_____

Comments_____

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(revised 12/18/2009)