Pleasant Hill Wellness Center

Occupational and Industrial Medicine
140 Gregory Lane, Suite #280
Pleasant Hill, Ca 94523
Ph: 925-288-0828 Fax: 925-288-0829

Employee Health Questionnaire

Name: _____ Date: _____
Last First MI

Address: _____ Phone: _____

Birthdate: _____ Social Security: _____

Employer: _____ Job Title: _____

Have you ever had or do you have any of the following medical problems? (Please check those that apply)

___ Severe Headaches	___ Loss of Consciousness	___ Epilepsy
___ Dizziness	___ Visual Problems	___ Hearing Problems
___ Shortness if Breath	___ Chronic Cough	___ Emphysema
___ Nervous Disorder	___ Asthma	___ High Blood Pressure
___ Chest Pain	___ Broken Bones	___ Skin Problems
___ Stomach Problems	___ Tumor or Cancer	___ Hernia
___ Kidney Problems	___ Drug Problems	___ Back Pain or Injury
___ Joint Pains or Injury	___ Heart Problems	___ Allergies
___ Diabetes	___ Black/Bloody Stool	___ Hepatitis
___ Tuberculosis	___ Arthritis	___ Alcohol Problems

___ Released from employment or the Armed Forces from medical or health reasons
___ Received or applied for pension or compensation for disability
___ Denied employment or insurance for medical reasons

Explain all "checked" answers: _____
_____
_____

Are you currently under a doctor's care? ____ yes ____ no
If "yes", for what problem: _____
_____

Do you smoke? ____ yes ____ no If "yes", how much/long: _____
Are you taking medications? ____ yes ____ no If "yes", please list: _____
_____

Have you ever had surgery? ____ yes ____ no If "yes", for what reason: _____
_____

Date of last menstrual period: _____ Any menstrual problems: _____

I hereby certify that all of the above answers are true to the best of my knowledge and that any misrepresentation may be cause for not being hired or for dismissal.

Signature: _____ Date: _____