CITY OF MONROE

MEDICAL HISTORY REPORT

Name_____ Soc. Sec. No. _____-_____-_____

Job Title _____ Department _____

The purpose of these questions is to gather information concerning your health and physical condition, both now and in the past. This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered. Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave it blank and request assistance.

I certify under penalty of perjury, that the information given by me is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment with the City of Monroe, or may result in loss of entitlement to disability retirement benefits, and/or a loss of my right to workers compensation benefits under Georgia law. My signature also indicates that I understand all of the questions on this medical history form.

EMPLOYEES' SIGNATURE: _____ DATE: _____

Individual History – To Be Completed By Applicant/Employee (Use Ink)

A. MEDICAL CONDITIONS. Check every item. Do you have or have you ever had any of the following: (If "Yes," give date of most recent occurrence and explain on page 3.)

Health Condition	*Yes*	*Year*	*No*
HEAD, NOSE, MOUTH AND THROAT			
1. Persistent or severe headaches			
2. Frequent nose bleeds			
3. Frequent nasal congestion			
4. Persistent or severe sinus condition			
5. Bleeding gums			
6. Persistent or severe dental condition			
7. Hoarse when don't have cold			
8. Difficulty swallowing			
9. Persistent sore throat			
10. Loss of taste or smell			
11. Head injury			
12. Other head, nose, mouth or throat conditions:			
EARS AND HEARING			
13. Hearing difficulties			
14. Use hearing aid			
15. Ringing in ears (tinnitus)			
16. Perforated ear drum			
17. Persistent or severe ear infection			
18. Other ear or hearing conditions			
EYES AND VISION			
19. Glaucoma			
20. Cataract			
21. Eye irritations (itching or burning)			
22. Eye infection			
23. Defective vision			
24. Color blindness			
25. Injury to eye			
26. Eye surgery			
27. Double vision			

Health Condition	*Yes*	*Year*	*No*
28. Glasses			
29. Contact lenses			
RESPIRATORY SYSTEM (lungs & breathing)			
30. Persistent or severe colds			
31. Persistent or severe cough			
32. Coughing blood			
33. Asthma or breathing difficulty			
34. Emphysema			
35. Pneumonia			
36. Tuberculosis			
37. Other lung or breathing condition:			
CARDIOVASCULAR SYSTEM (heart & blood vessels)			
39. Heart attack			
39. Hardening of the arteries (Arteriosclerosis)			
40 High or low blood pressure			
41. Heart murmur			
42. Palpitations or irregular heart beat			
43. Episodes of chest pains, tightness, discomfort			
44. Shortness of breath			
45. Varicose veins			
46. Swelling of ankles, feet or legs (edema)			
47. Leg pains, cramps			
48. Other cardiac conditions:			
GASTROINTESTINAL SYSTEM (stomach & intestines)			
49. Persistent or severe nausea or indigestion			
50. Persistent or severe stomach pain			
51. Vomiting blood			
52. Persistent or severe vomiting			
53. Hernia (rupture)			
54. Stomach or duodenal ulcer			

Health Condition	*Yes*	*Year*	*No*
55. Colitis			
56. Hemorrhoids or piles			
57. Change in bowel habits			
58. Black stool or blood in stool			
59. Persistent or severe constipation			
60. Persistent or severe diarrhea			
61. Pancreatitis			
62. Appendicitis			
63. Other conditions of stomach or intestines			
LIVER, SPLEEN & GALLBLADDER			
64. Cirrhosis			
65. Hepatitis			
66. Yellow jaundice			
67. Gallstones			
68. Other conditions of liver, spleen or gallbladder			
KIDNEYS & URINARY TRACT			
69. Kidney stones			
70. Kidney infection			
71. Blood or pus in urine			
72. Pain or burning when urinating			
73. Frequent urination			
74. Albumen or protein in urine			
75. Prostate condition			
76. Burning discharge from penis			
77. Other conditions of kidneys or urinary tract			
REPRODUCTIVE SYSTEM (FEMALES ONLY)			
78. Pregnant at present			
NEUROLOGICAL (Nervous) SYSTEM			
79. Epilepsy, convulsions, seizures			
80. Periods of blackouts/loss of consciousness			
81. Fainting spells			
82. Dizzy spells (vertigo)			
83. Memory difficulty			
84. Tremor of the hands or head			
85. Paralysis of any type			
86. Stroke			
87. Severe numbness, tingling or weakness			
88. Dyslexia/learning difficulty			
89. Other conditions of neurological (nervous) system:			
MUSCULOSKELETAL SYSTEM			
90. Arthritis			
91. Bursitis/tendonitis			
92. Swollen or painful joints			
93. Dislocations			
94. Painful or trick shoulder			
95. Elbow problems			
96. Wrist or hand problems			
97. Back pain			
98. Back surgery			

Health Condition	*Yes*	*Year*	*No*
99. Trick or locked knee			
100. Knee surgery			
101. Foot problems			
102. Bone infection			
103. Broken or fractured bone			
104. Persistent or severe muscle aches or pains			
105. Other Musculoskeletal conditions:			
ENDOCRINE/METABOLIC SYSTEM			
106. Diabetes			
107. Thyroid condition or disease			
108. Hypoglycemia			
109. Unexplained weight gain or loss			
110. Unusual loss or growth of body hair			
111. Gout			
112. Osteoporosis or other bone disease			
SKIN			
113. Rash			
114. Hives			
115. Moles that bleed or get larger			
116. Change in color of skin (other than suntan)			
117. Frequent boils/abscesses			
118. Trouble with fingernails			
119. Small itching blisters on the side of fingers or palms			
120. Sores that do not heal			
121. Other skin conditions:			
BLOOD/LYMPH (hematologic) SYSTEMS			
122. Anemia			
123. Bleeding disorder			
124 Sickle cell disease or trait			
125. Phlebitis/blood clot			
126. Blood transfusion			
127. Chills, fever, night sweats			
128. Lymph node or glandular swelling that persists			
129. Other conditions of blood or lymph:			
CANCER			
130. Surgery			
131. Radiation therapy			
132. Chemotherapy			
133. Immunotherapy			
134. Hormone therapy			
135. Breast			
136. Bone			
137. Skin			
138. Other			
PSYCHOLOGICAL/MOOD			
139. mental problem requiring hospitalization			
140. Suicidal/attempted suicide			
141. Active psychosis			
142. Drug, narcotic or alcohol			

Health Condition	*Yes*	*Year*	*No*
143. Persistent or severe depression/worry			
144. Other psychological conditions:			
INFECTIOUS OR CHILDHOOD DISEASES			
Meningitis/encephalitis			
146. Polio			
148. Mumps			
149. Measels			
150. Venereal Disease			
151. Other:			

Health Condition	*Yes*	*Year*	*No*
ALLERGIES (caused by)			
152. Medication			
147. Rheumatic fever			
153. Food			
154. Soaps or detergents			
155. Pollen			
156. Insect bites/scales			
157. Other:			

Explanation of items checked "Yes." Enter item number (1-157) before each comment.

_____

_____

_____

B. CURRENT MEDICATIONS :_____

_____

C. SURGICAL HISTORY

Have you ever had surgery? ☐ **Yes** ☐ **No**

[If "Yes, complete the following information about each surgery]

TYPE OF SURGERY DATE (Mo/Yr)

1. _____ _____

_____ _____

D. HOSPITALIZATION HISTORY

Have you ever been hospitalized? ☐ **Yes** ☐ **No**

[If "Yes," complete the following information about each hospitalization.]

REASON FOR HOSPITALIZATION DATE (Mo/Yr)

1. _____ _____
2. _____ _____
3. _____ _____