HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

PREPLACEMENT MEDICAL/PHYSICAL ASSESSMENT

Date:_____ Position Applied For:_____ SS# XXX-XX-_____

_____ _____ _____ Age____ Sex____ DOB:_____
Last Name First Initial

Address:_____ City/State/Zip_____

Home Phone:_____ Cell Phone:_____

Occupational Health History : Have you ever worked with materials that irritated your nose, eyes, lungs, and chest? Did these materials/chemicals make you feel "High" or lightheaded, or nauseated? If yes, explain:

Have you worked around:

	Yes	No		Yes	No
Dust	___	___	Anti-Neoplastic Drugs	___	___
Solvents	___	___	Radiation	___	___
Ethylene Oxide	___	___	Formaldehyde	___	___
Lasers	___	___	Anesthetic Gases	___	___

If any yes answers to above questions, please elaborate:
_____

Have you ever worked with asbestos or silica? _____ Where? _____When? _____

Health History:

In case of emergency notify: _____ _____ _____
Name Phone # Relationship

Who is your personal physician? _____ _____
Name Phone #

Are you allergic to any medications? _____ If yes what?_____
Are you taking any medications? _____ If yes, what? _____
_____

Immunization History: Please mark if you have had these immunizations. Enter the year when you were last given the "shot" or test.

	Year	
Tetanus	_____	
Hepatitis B Series	_____	(Titer Available? _____)
MMR	_____	(Titer Available? _____)
Varicella	_____	(Titer Available? _____)
BCG	_____	
Tuberculin Skin Test	_____	(Results Available? _____)
Chest X-Ray	_____	(Results Available? _____)
Seasonal Flu Vaccine	_____	

Smoking History:

Have you ever smoked cigarettes? No _____ Yes _____ How long? _____
Do you still smoke? No _____ Yes _____ How much? _____

Do you exercise regularly? Yes_____ No_____

Do you wear seat belts in the car? Yes_____ No_____

Medical History

Have you ever been told you have any of the following conditions? (Please place checkmark next to item(s).

1.____Alcoholism	2.____Allergies	3.____Anemia
4.____Arthritis	5.____Asthma	6.____Back trouble
7.____Back injury	8.____Bladder Disease	9.____Blood clot in vein
10.____Varicose veins	11.____Broken bones	12.____Bronchitis (chronic)
13.____Cancer	14.____Carpal tunnel syndrome	15.____Chest pain or angina
16.____Chronic cough	17.____Colitis	18.____Convulsions/Epilepsy
19.____Coronary disease	20.____Depression	21.____Diabetes
22.____Diarrhea (frequent)	23.____Dizziness	24.____Drug addiction
25.____Ear trouble	26.____Eczema	27.____Emphysema
28.____Eye problems	29.____Fainting spells	30.____Gall Bladder trouble
31.____Glaucoma	32.____Gout	33.____Head trauma
34.____Headaches (severe)	35.____Heart murmur	36.____Heart disease
37.____Hemorrhoids	38.____Herpes (cold sore)	39.____Hepatitis
40.____Hernia	41.____High blood pressure	42.____Knee trouble
43.____Kidney trouble/stones	44.____Liver problems	45.____Lung disease
46.____Menningitis	47.____Mental illness	48.____Mononucleosis
49.____Pneumonia	50.____Rashes	51.____Rheumatic Fever
52.____Polio	53.____Sciatica	54.____Stomach trouble
55.____Stroke	56.____Veneral Disease	57.____Thyroid trouble
58.____Tuberculosis	59.____Ulcer	60.____Tendonitis
61.____Chickenpox	62.____Rubella (German Measles)	63.____Rubeola (Measles)
64.____Mumps		

If any of the above answers are yes, indicate number and explain (approximate date followed by explanation).

_____

_____

Have you ever been hospitalized, (other than childbirth)? Yes ___ No ___

Year _____ Operation/illness _____

Year _____ _____

Do you wear glasses? Yes _____ No _____ Contact lenses? Yes _____ No _____

Last eye exam? (date) _____ Last dental exam? (date) _____

Have you ever been treated with radium, x-rays, radioactive isotopes? _____ Year _____

Do you have any current health problems? Yes _____ No _____

If yes, explain _____

Work/Service History:

Have you ever been disabled from a work related injury? Yes_____ No_____
If yes, give details: _____

Have you ever received any pension, insurance payment, or compensation for a work related injury or illness?
Yes _____ No_____ When? _____

Have you ever been rejected or discharged from military service because of illness or injury? If yes, explain:

_____

FEMALES ONLY

Date of last PAP Smear _____ Result _____
Date of last menstrual period _____Do you do self-breast exam? _____ How Often? _____

MALES ONLY

Do you self-testicular exam? _____ How Often? _____

___ Discharge from penis
___ Difficulty start stream
___ Testicular swelling or pain
___ Impotence

GENERAL HEALTH REVIEW

Please check any Present Condition:

General
___ Allergies
___ Sleep Disturbances
___ Excessive Thirst

Eyes
___ Double Vision
___ Blurred Vision
___ Eye Pain

Nose
___ Discharge
___ Obstruction
___ Frequent Colds
___ Excessive Bleeding

Gastro-Intestinal
___ Nausea/vomiting
___ Abdominal pain
___ Rectal Pains
___ Rectal Bleeding

Genito-Urinary
___ Frequent Urination
___ Painful Urination
___ Blood in Urine

Musculo-Skeletal
___ Frequent dislocations of a joint
___ Backaches
___ Joint swelling or pain
___ Painful feet or ankles
___ Limp
___ Torn ligaments
___ Inability to assume certain positions

Head/Neck
___ Headache/Migraine
___ Limited Movement
___ Lumps

Ears
___ Hard of Hearing
___ Discharge
___ Ringing

Mouth/Throat
___ Bleeding Gums
___ Sore Tongue
___ Dental Pain
___ Difficulty Swallowing
___ Hoarseness

Cardio-Respiratory
___ Shortness of breath
___ Chest pain
___ Heaviness in chest
___ Frequent cough
___ Spitting up blood
___ Wheezing
___ Extreme fatigue

Skin
___ Itching
___ Rashes
___ Lumps
___ Eczema
___ Psoriasis
___ Scaling

General Nervous System
___ Convulsions
___ Dizziness
___ Numbness or Tingling
___ Muscle Weakness
___ Memory Loss
___ Loss of Balance
___ Depression
___ Blackouts

I certify that all information contained in these personal medical history is true. I authorize its investigation and agree that any misleading or false statements would render my employment application void, and would be sufficient cause for immediate dismissal in the event of employment. I understand that this physical assessment does not duplicate or replace the physical done by my physician.

_____ _____

Date Signed **Signature of Applicant**