Steward
WorkMED

Name: _____

Company: _____

Position: _____

Home address/street _____ Home phone: (____) _____

City: _____ State: _____ Zip: _____ Work phone: (____) _____

Social Security Number: _____ Date of Birth: _____

Medical History

Mark with a ✓ if you have ever been diagnosed as having any of the following. Explain all "Yes" answers below:
If none of the below are applicable, please mark o None

Yes		Yes		Yes	
_____	Allergies	_____	Fainting/dizziness	_____	Kidney problems
_____	Alcoholism	_____	Fractures/dislocations	_____	Knee problems
_____	Angina	_____	Frequent headaches	_____	Leukemia
_____	Arthritis	_____	Frequent urination	_____	Liver disease
_____	Asthma	_____	Gastrointestinal disorder	_____	Loss of memory
_____	Back injury	_____	Genitourinary disorder	_____	Lung disease
_____	Bronchitis	_____	Glaucoma	_____	Menstrual difficulties
_____	Cancer	_____	Hay Fever	_____	Nervous problem
_____	Chest pain	_____	Hearing problem	_____	Psychiatric disorders
_____	Chronic cough	_____	Heart attack	_____	Rheumatic fever
_____	Dermatitis	_____	Heart murmur	_____	Shortness of breath
_____	Diabetes	_____	Hepatitis	_____	Sleep Disorders
_____	Drug	_____	Hernia	_____	Sleeplessness
_____	Alcohol abuse	_____	High blood pressure	_____	Thyroid
_____	Eczema	_____	Hives	_____	Tuberculosis
_____	Eyes/ears/nose disorder	_____	Hodgkin's disease	_____	Ulcers
_____	Emphysema	_____	Irregular heart beat	_____	Veneral disease
_____	Epilepsy/Seizures	_____	Joint problems	_____	Weight loss/gain
_____	Exposure to loud or continuous noise			_____	Zoster (shingles)

If Yes Explain: _____

_____

_____

Allergies to Medications: _____

Current Medications: _____

Surgical History: _____

Smoking History: Do you smoke ____ Yes ____ No ____ Quit _____ Amount per day

Immunization/Infection Hx:

	Infection or IMMUNIZATION / DATE		Infection or IMMUNIZATION / DATE
Chicken Pox	_____	Hepatitis	_____
Measles	_____	Tetanus	_____
Mumps	_____	Other	_____
Rubella	_____		

EMPLOYEE: *I hereby certify the above information is correct and truthful to the best of my knowledge. I am aware that medical information obtained during this examination will be made available to my employer or prospective employer and hereby give my consent to release this medical information to said parties. I also request and consent to the necessary physical examination as requested by my employer or other parties.*

Signature: _____ *Date* _____

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PPD Consent Form

I acknowledge that since I work in an area of increased risk of infection with M. tuberculosis, _____ (Company) has offered to give me the Mantoux P.P.D. I understand that I must have this test as a condition of employment. I am also aware that I must return to WORKMED in 48-72 hours to have the skin test read. However, as with all medical treatment, there is no guarantee I will not experience an adverse side effect from the Mantoux P.P.D. I request that the Mantoux P.P.D. be given to me and I hereby authorize WORKMED to administer it.

I also agree to release and hold WORKMED, its affiliates, including employees and agents harmless from any claim, adverse side effect(s) or injury that may arise by virtue of this test.

_____ Date

_____ Name of person to receive P.P.D. (Print)

_____ Witness

_____ Signature of person to receive P.P.D.

Address _____

_____

Telephone # _____

	YES	NO
Have you every been diagnosed with Tuberculosis?	_____	_____
Have you experienced any of the following symptoms within the last several weeks:		
• Persistent cough	_____	_____
• Weight loss	_____	_____
• Night sweats	_____	_____
• Bloody sputum	_____	_____
• Loss of appetite	_____	_____
• Fever	_____	_____
Have you had a previous P.P.D. skin test? If yes, what were the results? ____ Postive ____ Negative	_____	_____
Date of last Chest X-ray? _____ Normal	_____	_____
Have you ever had a B.C.G. vaccine?	_____	_____
If yes, when? _____		
Are you pregnant?	_____	_____