MAURY COUNTY PUBLIC SCHOOLS

COLUMBIA, TENNESSEE

MEDICAL HISTORY FORM

(To be completed by substitute)

Name: _____ Sex: _____

Social Security No.: _____ Date of Birth: _____

Work Location: _____ Home Phone: _____

Job Title: _____ Date of Employment: _____

Work Phone: _____ Personal Physician: _____

HISTORY: Have you ever had or do you presently have any of the following:

YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM
☐	☐	Anemia or Blood Disease	☐	☐	Hearing Problem
☐	☐	Arthritis	☐	☐	Heart Trouble
☐	☐	Asthma	☐	☐	High Blood Pressure
☐	☐	Back Problems	☐	☐	Kidney or Bladder Problems
☐	☐	Blood Disorders	☐	☐	Hepatitis or Jaundice (Liver Disorder)
☐	☐	Broken Bones	☐	☐	Nervousness or Emotional Problems
☐	☐	Bowel Disorder	☐	☐	Hemorrhoids/Rectal Problems
☐	☐	Cancer	☐	☐	Rheumatic Fever
☐	☐	Chest Pain	☐	☐	Hernia
☐	☐	Chronic Cough	☐	☐	Shortness of Breath
☐	☐	Dizziness	☐	☐	Swallowing Problems
☐	☐	Recent Fever	☐	☐	Stomach Disorders or Vomiting (Chronic)
☐	☐	Circulatory Problems	☐	☐	Sugar or Albumin in Urine
☐	☐	Diarrhea (Chronic)	☐	☐	Swelling of Ankles or Feet
☐	☐	Coughing Blood	☐	☐	Dental Problems (Chronic)
☐	☐	Deformities	☐	☐	Throat or Thyroid Problems
☐	☐	Diabetes	☐	☐	Tuberculosis
☐	☐	Eye Trouble	☐	☐	Varicose Veins or Phlebitis
☐	☐	Epilepsy	☐	☐	Venereal Disease
☐	☐	Foot Problems	☐	☐	Skin Problems or Rash (Boils)
☐	☐	Headaches	☐	☐	Herpes Simplex (Fever Blisters)
☐	☐	Indigestion Problems	☐	☐	Shingles
☐	☐	Gall Bladder Disorder	☐	☐	Ulcers
☐	☐	Menstrual Problems (Chronic)	☐	☐	Head Injury
☐	☐	Hay Fever or Sinus Problems	☐	☐	

DETAILS OF ANY PROBLEM CHECKED (YES);

_____

_____

_____

_____

Do you have any condition that may interfere with your ability to perform your job? Yes ☐ No ☐

If yes, explain: _____

_____

_____

Allergies: Indicate all substances to which you are allergic (examples: medicines and food):

Previous Surgery:

Previous Medications:

Family History: Does your immediate family (parents, brother, sister, children) have any significant problems such as:

☐ Cancer ☐ Heart Problems ☐ High Blood Pressure ☐ Diabetes ☐ TB

☐ Other:

Have you ever been compensated for an occupational disability or injury? Yes ☐ No ☐
If yes, explain:

Are you or have you ever been addicted to drugs, narcotics or alcohol? Yes ☐ No ☐
If yes, explain:

Do you have any condition that requires a special work assignment? Yes ☐ No ☐
If yes, explain:

Have you been admitted to the hospital in the last 2 years? Yes ☐ No ☐
If yes, explain:

I, the undersigned, do hereby certify that to the best of my knowledge, the answers provided to the questions above are true, that I have no physical or mental problems except as stated, and that I will openly discuss my physical and mental condition with the examining physician, if necessary.

I understand that any intentional omission or falsification of answers, either verbally or in writing above, may result in termination of my employment.

Employee's signature:

Date: