

POST-OFFER MEDICAL QUESTIONNAIRE

Employee Name: _____ Social Security Number: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____ Date of Birth: ____/____/____

PERSONAL HEALTH HISTORY

1. Have you ever had or been treated for any of the following conditions or diseases?

Head injury	☐ YES	☐ NO	Arthritis or rheumatism	☐ YES	☐ NO
Epilepsy, fainting spells, or dizziness	☐ YES	☐ NO	Tendonitis	☐ YES	☐ NO
Neck injury, pain, or problems	☐ YES	☐ NO	Repetitive motion disorders	☐ YES	☐ NO
Shoulder injury	☐ YES	☐ NO	Hip injury	☐ YES	☐ NO
£ Right Shoulder £ Left Shoulder			☐ Right Hip ☐ Left Hip		
Chest Pain	☐ YES	☐ NO	Knee injury	☐ YES	☐ NO
Back injury	☐ YES	☐ NO	☐ Right Knee ☐ Left Knee		
Herniated Disc	☐ YES	☐ NO	Foot/ankle/toe injury	☐ YES	☐ NO
Diseased process of the spine	☐ YES	☐ NO	☐ Right foot/ankle/toe ☐ Left foot/ankle/toe		
Surgical removal of disc/spinal fusion	☐ YES	☐ NO	Ankylosis	☐ YES	☐ NO
Hernia or rupture	☐ YES	☐ NO	Immobility of any major, weight-bearing joints (ankles, knees, hips)		
Arm/hand/fingers injury	☐ YES	☐ NO	☐ Right side ☐ Left side		
☐ Right arm/hand/finger ☐ Left arm/hand/finger			Broken bones	☐ YES	☐ NO
Wrist problems (including Carpal Tunnel)	☐ YES	☐ NO	Amputations	☐ YES	☐ NO
☐ Right Wrist ☐ Left Wrist					

2. Describe any conditions checked "YES" from above: _____

3. Have you had any prior surgeries or sought treatment from a healthcare provider for any of the above injuries and/or medical conditions?
☐ YES ☐ NO

4. Are you capable of performing the essential duties of this job function? ☐ YES ☐ NO

5. Do you have an injury or condition that requires a reasonable accommodation for you to be able to perform the essential duties of this job position? ☐ YES ☐ NO

If yes, what accommodations do you need to perform the job? _____

6. How much weight can you lift comfortably unassisted?

☐ < 15 lbs ☐ 15-25 lbs ☐ 25-39 lbs ☐ ≥ 40 lbs

7. Has a healthcare provider placed any limitation on your ability to sit, stand, push, pull, or lift? ☐ YES ☐ NO

If yes, what are the limitations? _____

8. Has a healthcare provider limited the amount of weight you can lift? ☐ YES ☐ NO

If yes, list the weight limitation and the date that your healthcare provider issued you the limitation: _____

9. Are you taking any prescribed drugs that would interfere with your ability to safely perform your job? ☐ YES ☐ NO

If yes, list the medications: _____

10. Have you ever been hurt on the job or filed a Workers' Compensation claim? ☐ YES ☐ NO

If yes: Date(s): _____

Treating physician(s): _____

Body part(s): _____

COVID-19 VACCINATION HISTORY

1. Have you received the COVID-19 Vaccine? ☐ YES ☐ NO
2. Will you provide us with a certified copy of your vaccine card? ☐ YES ☐ NO ☐ N/A
3. Date of 1st Vaccination (if applicable): _____
Select vaccine received: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson
4. Date of 2nd Vaccination (if applicable): _____
Select vaccine received: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson
5. Date of 1st Booster received (if applicable): _____
Select vaccine received: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson
6. Date of 2nd Booster received (if applicable): _____
Select vaccine received: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson
7. Date of 3rd Booster received (if applicable): _____
Select vaccine received: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson
8. Date of 4th Booster received (if applicable): _____
Select vaccine received: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.

Signature of Employee _____
Printed Name _____
Date _____

 Company Representative Date

Signature of Employee

Printed Name

Date