

### Pre-placement Questionnaire

<b>Name</b>	<b>Date of Birth</b>	<b>Gender</b>	<b>Date</b>
<b>Phone Number (Cell/Home)</b>	<b>Email</b>	<b>Position Applied For</b>	<b>Department</b>
<b>Hiring Manager</b>	<b>Start Date</b>	<b>List Previous Occupations</b>	
Exposures – Occupational/Recreational (include animal, chemical, heavy metal (e.g. mercury), or fibers (e.g. asbestos))		Medications and Supplements (Please list prescribed and over the counter items whether taken daily or as needed)	
Allergies (include medication allergy or reactions, animals, foods, season/environmental/chemical, latex, etc.)			

#### PAST/CURRENT MEDICAL HISTORY (Please explain yes answers below with number)

	CHECK EACH ITEM	YES	NO		CHECK EACH ITEM	YES	NO		CHECK EACH ITEM	YES	NO
1	Anemia or other blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	21	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	41	Back/neck problems or recurrent injuries	<input type="checkbox"/>	<input type="checkbox"/>
2	Bleeding disorders or bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	22	Palpitation or pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	42	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
3	Rashes, eczema or other skin problems	<input type="checkbox"/>	<input type="checkbox"/>	23	Pain or pressure in chest	<input type="checkbox"/>	<input type="checkbox"/>	43	Muscle problems	<input type="checkbox"/>	<input type="checkbox"/>
4	Head injury/concussion	<input type="checkbox"/>	<input type="checkbox"/>	24	Rheumatic or scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	44	Balance or coordination problems	<input type="checkbox"/>	<input type="checkbox"/>
5	Stroke, aneurysm or bleeding in brain	<input type="checkbox"/>	<input type="checkbox"/>	25	Abnormal EKG	<input type="checkbox"/>	<input type="checkbox"/>	45	Fibromyalgia or chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
6	Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	26	Frequent cramps in your legs	<input type="checkbox"/>	<input type="checkbox"/>	46	CT, MRI scan or other special tests	<input type="checkbox"/>	<input type="checkbox"/>
7	Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	27	Phlebitis or varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	47	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
8	Epilepsy or seizure	<input type="checkbox"/>	<input type="checkbox"/>	28	Stomach or intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	48	Unconsciousness for any reason	<input type="checkbox"/>	<input type="checkbox"/>
9	Loss of memory or amnesia	<input type="checkbox"/>	<input type="checkbox"/>	29	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	49	Current drugs or substance dependence or abuse	<input type="checkbox"/>	<input type="checkbox"/>
10	Eye or vision problems	<input type="checkbox"/>	<input type="checkbox"/>	30	Jaundice or hepatitis/liver disease	<input type="checkbox"/>	<input type="checkbox"/>	50	Frequent trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>
11	Color vision difficulty	<input type="checkbox"/>	<input type="checkbox"/>	31	Pancreatic/spleen disease	<input type="checkbox"/>	<input type="checkbox"/>	51	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
12	Wear corrective lenses/glasses	<input type="checkbox"/>	<input type="checkbox"/>	32	Kidney/bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	52	Asthma/wheezing	<input type="checkbox"/>	<input type="checkbox"/>
13	Hearing loss or hearing aid use	<input type="checkbox"/>	<input type="checkbox"/>	33	Arthritis, Rheumatism, joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	53	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
14	Other ear problems	<input type="checkbox"/>	<input type="checkbox"/>	34	Dislocation of any joint	<input type="checkbox"/>	<input type="checkbox"/>	54	Frequent colds or lung infections	<input type="checkbox"/>	<input type="checkbox"/>
15	Frequent rhinitis or sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	35	Hand/wrist problems or any difficulty grasping	<input type="checkbox"/>	<input type="checkbox"/>	55	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
16	Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	36	Carpal tunnel	<input type="checkbox"/>	<input type="checkbox"/>	56	Tuberculosis or positive TB test	<input type="checkbox"/>	<input type="checkbox"/>
17	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	37	Numbness or tingling in fingers or toes or other nerve problems	<input type="checkbox"/>	<input type="checkbox"/>	57	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
18	Diabetes or blood sugar problems	<input type="checkbox"/>	<input type="checkbox"/>	38	Shoulder/elbow problems or recurrent injuries	<input type="checkbox"/>	<input type="checkbox"/>	58	Other health problems not mentioned above	<input type="checkbox"/>	<input type="checkbox"/>
19	Tumor, growth, cyst or cancer	<input type="checkbox"/>	<input type="checkbox"/>	39	Hip/knee problems or recurrent injuries	<input type="checkbox"/>	<input type="checkbox"/>				
20	Problems related to the heart	<input type="checkbox"/>	<input type="checkbox"/>	40	Foot/ankle problems or recurrent injuries	<input type="checkbox"/>	<input type="checkbox"/>				

<b>NAME:</b> _____	<b>DATE OF BIRTH:</b> _____
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“YES” Answers to Past/Current Medical History (please place corresponding number from above with comments; use back of page or attach sheet if more space is required)

<b>CHECK EACH ITEM</b>			
(Please explain yes answers in the area to the right)			
ITEM	YES	NO	Explanation: _____
Have you ever been told to restrict your physical activity at work?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there any equipment that is necessary to help you best perform your job activities (e.g. phone headset, special chair, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any health condition(s) that may interfere with your ability to perform your basic job duties in a healthy and safe manner?	<input type="checkbox"/>	<input type="checkbox"/>	
Please check below if you may be working with the following:			
<input type="checkbox"/> Blood/Bodily Fluids <input type="checkbox"/> Lasers <input type="checkbox"/> Research Animals <input type="checkbox"/> Chemicals <input type="checkbox"/> Radiation <input type="checkbox"/> Other (Please list): _____			
DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING (CHECK ANY THAT APPLY):			
<input type="checkbox"/> prolonged sitting <input type="checkbox"/> prolonged standing <input type="checkbox"/> prolonged walking <input type="checkbox"/> reaching above shoulder level <input type="checkbox"/> lifting over 45 pounds <input type="checkbox"/> carrying over 35 pounds <input type="checkbox"/> forceful push <input type="checkbox"/> forceful pull			
DO YOU HAVE ANY DIFFICULTY USING THE FOLLOWING (CHECK ANY THAT APPLY):			
<input type="checkbox"/> Gloves (specify types) <input type="checkbox"/> Respirator (specify types) <input type="checkbox"/> Tyvex overalls <input type="checkbox"/> Hearing protection (ear plugs/ muffs)			
By signing below, I signify that the above answers are true and accurate to the best of my knowledge:			
SIGNATURE OF APPLICANT: _____		DATE SIGNED: _____	

<b>Physical Data (OEM Staff Only)</b>				
Height: _____	Weight: _____	Blood Pressure: _____	Pulse: _____	BMI: _____
Visual Acuity	Without corrective lenses		With corrective lenses	
Far Vision	Right 20/____ Left 20/____ Both20/____		Right 20/____ Left 20/____ Both20/____	
Near Vision	Right 20/____ Left 20/____ Both20/____		Right 20/____ Left 20/____ Both20/____	
Visual Fields	Right _____ degrees		Left _____ degrees	
Color Vision	Ishihara: Normal _____	Abnormal: _____	Yarn Test: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	
Hearing	Whisper at 6 feet: <input type="checkbox"/> Pass <input type="checkbox"/> Fail		Spoken voice 4 feet: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	