SCOTTSDALE HEALTHCARE℠

Health Questionnaire

☐ 3501 N. Scottsdale Rd #231
Scottsdale, AZ 85251
Phone: (480) 882-4770
Fax: (480) 882-4391

☐ 10200 N. 92nd St., Ste. 102
Scottsdale, AZ 85260
Phone: (480) 323-3818
Fax: (480) 323-3238

☐ 16101 N. 82nd Street, Suite A-8
Scottsdale, AZ 85260
Phone: (480) 323-1880
Fax: (480) 905-1136

☐ Other

The information acquired from this health questionnaire and the pre-placement exam is **confidential**. Only that information which applies to the position for which you are being hired will be used to assess your ability to perform the job. A recommendation will be made to the employer based upon this information.

Name – Last	First	M.I.	Age	Date of Birth	Social Security #

Address	City	State	Zip	Phone
				( )

Personal Healthcare Provider - Name	Address	Phone
		( )

Emergency Data - Name & Relationship	Address	Phone
		( )

Employment Data - Company Name	Address

Department	Job Title	Name of Supervisor	Phone
			( )

Work History

Yes	*No*	
☐	☐	Have you had a job related illness? If yes, _____
☐	☐	Have you had a job related injury? If yes, _____
☐	☐	Have you served in the military? If yes, which branch _____

Occupational Exposure

Yes	*No*		*Yes*	*No*	
☐	☐	Asbestos	☐	☐	Loud Noise
☐	☐	Dust	☐	☐	Solvents/Chemicals
☐	☐	Extreme Heat/Cold	☐	☐	Vapors/Gases
☐	☐	Infectious Agents	☐	☐	Vibration

☐ ☐ Have you had any adverse reactions to exposures? If yes, describe: _____

☐ ☐ Do you feel you have any health problems related to your work? If yes, describe: _____

Medical History

Yes *No*

☐ ☐ Do you currently take medications? If yes, list medication and condition for treatment::

Medication	*Condition*	*Medication*	*Condition*

☐ ☐ Have you had inpatient or outpatient operations/injuries/Illnesses? If yes, complete list below:

Date	*Operation/Injury/Illness*

☐ ☐ Have you ever had a reaction, allergy and/or sensitivity to drugs, food, plants, animals, latex gloves or any other substance? If yes, complete list below:

Medication/Substance	*Reaction*

Medical History (continued)

Have you had or do you have any of the following (check all that apply). If yes, indicate the year it occurred. List response to 'Yes' in Comments section.

Yes	*No*		*Year*	*Yes*	*No*		*Year*	*Yes*	*No*		*Year*
☐	☐	Abdominal pain	_____	☐	☐	Frequent dislocation	_____	☐	☐	Neck Pain	_____
☐	☐	Backache	_____	☐	☐	Frequent head colds	_____	☐	☐	Nose obstruction	_____
☐	☐	Blackouts	_____	☐	☐	Frequent urination	_____	☐	☐	Numbness	_____
☐	☐	Bleeding gums	_____	☐	☐	Hard of hearing	_____	☐	☐	OB or GYN disorders	_____
☐	☐	Blood in urine	_____	☐	☐	Headache	_____	☐	☐	Painful feet or ankles	_____
☐	☐	Blurred vision	_____	☐	☐	Hepatitis B	_____	☐	☐	Painful urination	_____
☐	☐	Change of bowel habits	_____	☐	☐	Hepatitis C	_____	☐	☐	Pregnant, due date:	_____
☐	☐	Chest pain	_____	☐	☐	HIV	_____	☐	☐	Rectal pain	_____
☐	☐	Chronic pain	_____	☐	☐	Itching skin	_____	☐	☐	Ringing in ears	_____
☐	☐	Convulsions	_____	☐	☐	Joint swelling/pain	_____	☐	☐	Severe head trauma	_____
☐	☐	Dental pain	_____	☐	☐	Limited neck movement	_____	☐	☐	Shortness of breath	_____
☐	☐	Depression	_____	☐	☐	Limp	_____	☐	☐	Skin rashes	_____
☐	☐	Discharge from ears	_____	☐	☐	Loss of balance	_____	☐	☐	Sleep disorder	_____
☐	☐	Dizziness	_____	☐	☐	Lumps in neck	_____	☐	☐	Sore tongue	_____
☐	☐	Double vision	_____	☐	☐	Lumps on skin	_____	☐	☐	Spitting up blood	_____
☐	☐	Earache	_____	☐	☐	Memory loss	_____	☐	☐	Substance abuse	_____
☐	☐	Excessive nose bleeding	_____	☐	☐	Migraine	_____	☐	☐	Torn ligaments	_____
☐	☐	Excessive thirst	_____	☐	☐	Muscle weakness	_____	☐	☐	Wheezing	_____
☐	☐	Eye pain	_____	☐	☐	Nausea or vomiting	_____				
☐	☐	Frequent cough	_____								

Comments: _____

_____

_____

_____

_____

Immunizations

Yes	*No*		*Date*	*Yes*	*No*		*Date*
☐	☐	Hepatitis B (1,2,3,titer)	_____	☐	☐	Tetanus	_____
☐	☐	Measles	_____	☐	☐	TB Skin Test	_____
☐	☐	Mumps	_____	☐	☐	Reaction to TB Skin Test. If yes, explain _____	
☐	☐	Rubella	_____	☐	☐	Other, describe: _____	

I hereby certify that the information contained in this health questionnaire for employment is true and correct. Any omission or misrepresentation of facts may be a basis for termination pending employer's policy.

_____ _____

Signature Date

Provider's Notes: _____

_____

_____

_____

Provider's Signature Date

_____ _____