HEALTH SCREENING

YOUR HEALTH _____GOOD _____FAIR _____POOR

Any health limitations? _____

Have you had a back injury? _____YES _____NO

If yes, when and what medical measures were provided? _____

_____

Have you ever had or been treated for Tuberculosis? _____YES _____NO

Do you have Diabetes? _____YES _____NO
Do you have Hypertension? _____YES _____NO

Impaired Hearing? _____YES _____NO
Do you wear glasses or contact lenses? _____YES _____NO

Are you currently taking or on a daily prescribed medication? _____YES _____NO
If yes, what type and purpose. _____

_____

Date of last complete Physical Exam? _____

Your Physician's name: _____

Telephone Number: _____

May we have your permission to talk with your Physician? _____YES _____NO

Have you had any major illness, surgery or been hospitalized in the last 2 years?
_____YES _____NO

What is your weight? _____
What is your height? _____

In an emergency, notify _____ Relationship _____
Telephone Number _____