MUSTARDSEED HEALTHCARE SERVICES LLC

Employee Health Questionnaire

Last Name _____ First Name _____ Initial _____ Age _____ Se

ADDRESS: _____

POSITION APPLIED FOR: _____ DATE _____

FAMILY PHYSICIAN: _____ DATE: _____

REASON FOR LAST VISIT: _____

FAMILY HISTORY: **Nervous or Mental Illness** [ ]YES [ ]NO; **Diabetes** [ ]YES [ ]NO; **Tuberculosis** [ ]YES [ ]NO

Have you or do you have any of the following? (Check 'Yes' or 'No' after each question)

Disease of:

	YES	NO
Fainting Spells	[ ]	[ ]
Hypertension	[ ]	[ ]
Diabetes	[ ]	[ ]
Asthma	[ ]	[ ]
Back Injuries	[ ]	[ ]
Jaundice	[ ]	[ ]

	YES	NO
Nervous Breakdown	[ ]	[ ]
Malaria	[ ]	[ ]
Arthritis	[ ]	[ ]
Hernia (Rupture)	[ ]	[ ]
Tuberculosis	[ ]	[ ]

Have you ever worn a back brace?	[ ] [ ]
Have you ever received worker's compensation?	[ ] [ ]
Have you ever been refused insurance for health reasons?	[ ] [ ]
Do you take medicine regularly?	[ ] [ ]
Have you ever had heart trouble?	[ ] [ ]
Have you ever been a patient in a hospital or institution during the last three years?	[ ] [ ]
Have you ever received pension or disability insurance?	[ ] [ ]
Have you ever been refused employment for health reasons?	[ ] [ ]
Do you have any defect, deformity or disease which may interfere with your work?	[ ] [ ]

State details of illness, injuries, operation or defects: _____

_____

_____

I, the undersigned, certify the above answers are true, and give the Examining physician permission to submit a report to MUSTARDSEED HEALTHCARE SERVICES LLC.

Signature: _____ Date: _____