

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

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

Please initial your acknowledgement of the following statements.

_____ **NOTICE TO OFFEREES:** In compliance with the Americans with Disabilities Act of 2008 (ADA), you have received a conditional offer of employment. This medical history statement is required of all offerees. The answers to the medical history statement and any medical examination will be kept confidential and in separate files in compliance with the ADA requirements. The job offer, which you have received, is conditioned upon satisfactory completion and review of this medical questionnaire and any required medical examination or follow up.

_____ **GINA DISCLOSURE:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____ **EMPLOYEE AFFIRMATION:** I herewith affirm that the employer has made me an offer of employment, conditioned on, among other things, the satisfactory completion of this questionnaire. The purpose of this inquiry is as follows: (1) to determine whether I currently have the physical qualifications necessary to perform the essential functions of the job that has been offered; (2) to determine what accommodations, if any, may be necessary for me to perform the essential functions of the job; and (3) to determine whether I can perform the essential functions of the job without posing a significant direct threat to the health and safety of myself and others. This information will be kept strictly confidential in a separate medical file, apart from my personnel file. I hereby affirm that the questions in the medical questionnaire have not been asked of me by anyone with the employer until after I have signed this statement and been offered a conditional job. The conditional job duties have been adequately described to me, and I have had an opportunity to ask questions regarding the duties.

Signature of Employee

Printed Name

Date