RIVERSIDE

MEDICAL HISTORY QUESTIONNAIRE

This questionnaire is for the purpose of obtaining a complete health profile and to comply with the Americans with Disabilities Act. Further, the information will allow your employer to evaluate and provide reasonable accommodation for any qualifying disability you may have. This Information will be kept confidential in a separate medical file, apart from your personnel file. **IMPORTANT:** Any employee who falsely represents his condition in writing or by omission at the time of entering into the employment relationship with the employer may be denied Workers' Compensation benefits; in addition, any false representation at this time may subject the employee to termination.

NAME_____SSN_____POSITION/DEPT_____

ADDRESS _____ CITY/ZIP _____

TELEPHONE_____EMAIL_____DOB_____AGE_____FAMILY PHYSICIAN_____

EMERGENCY CONTACT: (NAME) _____ TELEPHONE _____RELATIONSHIP _____

PERSONAL EMAIL ADDRESS: _____

INSTRUCTIONS: Indicate YES or NO to the following questions and give dates for any yes answers. Give details below for any "YES" answer. Do not skip any questions.

Have you ever had or been treated for any of the following conditions or diseases?	YES or NO	Date		YES or NO	Date
1 Severe Headaches	No		15 Skin Trouble	No	
2 Dizziness or fainting spells	No		16 Tuberculosis	No	
3 Seizure/Epilepsy	No		17 Hepatitis A, B, or C	No	
4 Anemia/Hemophilia/other blood disorder	No		18 Alcoholism/Drug Addiction/Substance Misuse	No	
5 Diabetes/Blood Sugar issues (high/Low)	No		19 Nervous breakdown, Mental illness, Psychiatric treatment or counseling	No	
6 Cardiac Disease/ Chest Pain	No		20 Head / Neck or Back Injury	No	
7 High blood pressure	No		21 Leg/Knee/Hip/Ankle injury	No	
8 Thrombophlebitis (inflammation of vein or blood clot)	No		22 Elbow/Shoulder/Wrist/Arm Hand injury	No	
9 Asthma/Respiratory disorder	No		23 Repetitive strain /Carpel Tunnel Syndrome	No	
10 Shortness of breath	No		24 Any fracture or broken bones	No	
11 Hearing issues/loss	No		25 Any other orthopedic surgery	No	
12 Learning Disability	No		26 Are there any question(s) above that you do not understand	No	
13 Eye/Vision conditions (glasses, contacts, color blindness, etc.)	No		27 Are you allergic to Latex?	No	
14 Hernia (rupture)	No		28 Do you smoke / chew tobacco/Vape-e-cigarettes?	No	

29. Do you have any underlying medical conditions?

_____

30. Please list Prescriptions / Over The Counter Medications/ Valid Virginia written Certification for use of cannabidiol oil or THC- A oil for treatment and why you are taking them

_____

_____

31. Are you presently undergoing treatment by a medical doctor, chiropractor, psychologist/psychiatrist, physical therapist or other health care provider, if so please list each healthcare provider individually and the condition for which they are treating Please provide full name, address and phone number:

_____.

32. Medication Allergies/Untoward Reactions?_____

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33. Have you ever been hospitalized (other than childbirth) in the past 5 years? No If so, for what? _____

34. Have you ever filed a Workers' Compensation claim, or received money in the form of lost wages/lump sum settlement as a result of a Workers' Compensation claim? No Explain: _____

_____

35. Do you have any permanent physical condition, for which you received an impairment rating? No Explain: _____

_____

36. Is there any health-related reason you may not be able to perform the job which you have been offered? No Explain:

_____

_____

** **If yes attach medical documentation**

37. Do you have any physical or mental limitations which prevent you from performing certain kinds of work? No If yes, please describe such specific work limitations/restrictions **and attach medical documentation:** _____

_____

38. Based upon your review of your job description and the essential functions of your job, do you require any accommodation? No Explain: _____

_____

Please attach immunization record if possible

I understand that the Hepatitis B vaccine will be offered to all employees that have the potential for exposure to blood or body fluids within their normal job description. This vaccine will be offered at no cost to the employee.

ALL STATEMENTS AND INFORMATION GIVEN IN THIS HISTORY ARE TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. THESE QUESTIONS WERE NOT ASKED OF ME UNTIL AFTER I WAS OFFERED A JOB.

I understand that my employment is contingent upon the approval and completion of this medical assessment. I understand refusal to submit to or cooperate with this assessment is reason for termination of the employment process. I authorize Riverside Health System to obtain both verbal and written medical information from all my healthcare providers upon request. This authorization is valid from 90 days from the date of my signature below or until revoked sooner by me in writing. In addition I authorize Riverside Health System to provide this medical history questionnaire to my healthcare providers. I understand that I may be requested to see a physician designated by Riverside Health System for another evaluation without cost to myself; however, any follow up needed as a result of this post offer, pre-placement evaluation will be my responsibility.

A photocopy of this Consent and Release form shall have the same effect as the original. I understand that any false representation of my medical history in writing or by omission at the time of entering into the employment relationship with the employer may be denied Workers' Compensation benefits; in addition, any false representation at this time may subject the employee to termination.

Applicants name (Printed) _____ Date of Birth: _____

Applicants Signature _____ Date _____

Reviewer name (Printed) _____

Reviewer Signature _____ Date _____