**STATE OF GEORGIA** Name_____ Soc. Sec. No. _____-_____-_____

**MEDICAL AND PHYSICAL** Job Title _____ Department _____

**EXAMINATION PROGRAM**

**MEDICAL HISTORY REPORT** Job Category (circle one) 1 2 3 4 5

The purpose of these questions is to gather information concerning your health and physical condition, both now and in the past. This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered. Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave it blank and request assistance.

I certify under penalty of perjury, that the information given by me is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia, may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this medical history form.

EMPLOYEES' SIGNATURE: _____ DATE: _____

**Individual History – To Be Completed By Applicant/Employee (Use Ink)**

**A. MEDICAL CONDITIONS**. Check every item. Do you have or have you ever had any of the following: (If "Yes," give date of most recent occurrence and explain on page 3.)

| *Health Condition* | *Yes* | *Year* | *No* |
|---|---|---|---|
| HEAD, NOSE, MOUTH AND THROAT | | | |
| 1. Persistent or severe headaches | | | |
| 2. Frequent nose bleeds | | | |
| 3. Frequent nasal congestion | | | |
| 4. Persistent or severe sinus condition | | | |
| 5. Bleeding gums | | | |
| 6. Persistent or severe dental condition | | | |
| 7. Hoarse when don't have cold | | | |
| 8. Difficulty swallowing | | | |
| 9. Persistent sore throat | | | |
| 10. Loss of taste or smell | | | |
| 11. Head injury | | | |
| 12. Other head, nose, mouth or throat conditions: | | | |
| EARS AND HEARING | | | |
| 13. Hearing difficulties | | | |
| 14. Use hearing aid | | | |
| 15. Ringing in ears (tinnitus) | | | |
| 16. Perforated ear drum | | | |
| 17. Persistent or severe ear infection | | | |
| 18. Other ear or hearing conditions | | | |
| EYES AND VISION | | | |
| 19. Glaucoma | | | |
| 20. Cataract | | | |
| 21. Eye irritations (itching or burning) | | | |
| 22. Eye infection | | | |
| 23. Defective vision | | | |
| 24. Color blindness | | | |
| 25. Injury to eye | | | |
| 26. Eye surgery | | | |
| 27. Double vision | | | |
| | | | |

| *Health Condition* | *Yes* | *Year* | *N o* |
|---|---|---|---|
| 28. Glasses | | | |
| 29. Contact lenses | | | |
| RESPIRATORY SYSTEM (lungs & breathing) | | | |
| 30. Persistent or severe colds | | | |
| 31. Persistent or severe cough | | | |
| 32. Coughing blood | | | |
| 33. Asthma or breathing difficulty | | | |
| 34. Emphysema | | | |
| 35. Pneumonia | | | |
| 36. Tuberculosis | | | |
| 37. Other lung or breathing condition: | | | |
| CARDIOVASCULAR SYSTEM (heart & blood vessels) | | | |
| 39. Heart attack | | | |
| 39. Hardening of the arteries (Arteriosclerosis) | | | |
| 40 High or low blood pressure | | | |
| 41. Heart murmur | | | |
| 42. Palpitations or irregular heart beat | | | |
| 43. Episodes of chest pains, tightness, discomfort | | | |
| 44. Shortness of breath | | | |
| 45. Varicose veins | | | |
| 46. Swelling of ankles, feet or legs (edema) | | | |
| 47. Leg pains, cramps | | | |
| 48. Other cardiac conditions: | | | |
| GASTROINTESTINAL SYSTEM (stomach & intestines) | | | |
| 49. Persistent or severe nausea or indigestion | | | |
| 50. Persistent or severe stomach pain | | | |
| 51. Vomiting blood | | | |
| 52. Persistent or severe vomiting | | | |
| 53. Hernia (rupture) | | | |
| 54. Stomach or duodenal ulcer | | | |
| | | | |

| Health Condition | Yes | Year | No | | Health Condition | Yes | Year | No |
|---|---|---|---|---|---|---|---|---|
| 55. Colitis | | | | | 99. Trick or locked knee | | | |
| 56. Hemorrhoids or piles | | | | | 100. Knee surgery | | | |
| 57. Change in bowel habits | | | | | 101. Foot problems | | | |
| 58. Black stool or blood in stool | | | | | 102. Bone infection | | | |
| 59. Persistent or severe constipation | | | | | 103. Broken or fractured bone | | | |
| 60. Persistent or severe diarrhea | | | | | 104. Persistent or severe muscle aches or pains | | | |
| 61. Pancreatitis | | | | | 105. Other Musculoskeletal conditions: | | | |
| 62. Appendicitis | | | | | ENDOCRINE/METABOLIC SYSTEM | | | |
| 63. Other conditions of stomach or intestines | | | | | 106. Diabetes | | | |
| LIVER, SPLEEN & GALLBLADDER | | | | | 107. Thyroid condition or disease | | | |
| 64. Cirrhosis | | | | | 108. Hypoglycemia | | | |
| 65. Hepatitis | | | | | 109. Unexplained weight gain or loss | | | |
| 66. Yellow jaundice | | | | | 110. Unusual loss or growth of body hair | | | |
| 67. Gallstones | | | | | 111. Gout | | | |
| 68. Other conditions of liver, spleen or gallbladder | | | | | 112. Osteoporosis or other bone disease | | | |
| KIDNEYS & URINARY TRACT | | | | | SKIN | | | |
| 69. Kidney stones | | | | | 113. Rash | | | |
| 70. Kidney infection | | | | | 114. Hives | | | |
| 71. Blood or pus in urine | | | | | 115. Moles that bleed or get larger | | | |
| 72. Pain or burning when urinating | | | | | 116. Change in color of skin (other than suntan) | | | |
| 73. Frequent urination | | | | | 117. Frequent boils/abscesses | | | |
| 74. Albumen or protein in urine | | | | | 118. Trouble with fingernails | | | |
| 75. Prostate condition | | | | | 119. Small itching blisters on the side of fingers or palms | | | |
| 76. Burning discharge from penis | | | | | 120. Sores that do not heal | | | |
| 77. Other conditions of kidneys or urinary tract | | | | | 121. Other skin conditions: | | | |
| REPRODUCTIVE SYSTEM (FEMALES ONLY) | | | | | BLOOD/LYMPH (hematologic) SYSTEMS | | | |
| 78. Pregnant at present | | | | | 122. Anemia | | | |
| NEUROLOGICAL (Nervous) SYSTEM | | | | | 123. Bleeding disorder | | | |
| 79. Epilepsy, convulsions, seizures | | | | | 124 Sickle cell disease or trait | | | |
| 80. Periods of blackouts/loss of consciousness | | | | | 125. Phlebitis/blood clot | | | |
| 81. Fainting spells | | | | | 126. Blood transfusion | | | |
| 82. Dizzy spells (vertigo) | | | | | 127. Chills, fever, night sweats | | | |
| 83. Memory difficulty | | | | | 128. Lymph node or glandular swelling that persists | | | |
| 84. Tremor of the hands or head | | | | | 129. Other conditions of blood or lymph: | | | |
| 85. Paralysis of any type | | | | | CANCER | | | |
| 86. Stroke | | | | | 130. Surgery | | | |
| 87. Severe numbness, tingling or weakness | | | | | 131. Radiation therapy | | | |
| 88. Dyslexia/learning difficulty | | | | | 132. Chemotherapy | | | |
| 89. Other conditions of neurological (nervous) system: | | | | | 133. Immunotherapy | | | |
| MUSCULOSKELETAL SYSTEM | | | | | 134. Hormone therapy | | | |
| 90. Arthritis | | | | | 135. Breast | | | |
| 91. Bursitis/tendonitis | | | | | 136. Bone | | | |
| 92. Swollen or painful joints | | | | | 137. Skin | | | |
| 93. Dislocations | | | | | 138. Other | | | |
| 94. Painful or trick shoulder | | | | | PSYCHOLOGICAL/MOOD | | | |
| 95. Elbow problems | | | | | 139. mental problem requiring hospitalization | | | |
| 96. Wrist or hand problems | | | | | 140. Suicidal/attempted suicide | | | |
| 97. Back pain | | | | | 141. Active psychosis | | | |
| 98. Back surgery | | | | | 142. Drug, narcotic or alcohol | | | |

| *Health Condition* | *Yes* | *Year* | *No* | | *Health Condition* | *Yes* | *Year* | *No* |
|---|---|---|---|---|---|---|---|---|
| 143. Persistent or severe depression/worry | | | | | ALLERGIES (caused by) | | | |
| 144. Other psychological conditions: | | | | | 152. Medication | | | |
| INFECTIOUS OR CHILDHOOD DISEASES | | | | | 147. Rheumatic fever | | | |
| Meningitis/encephalitis | | | | | 153. Food | | | |
| 146. Polio | | | | | 154. Soaps or detergents | | | |
| 148. Mumps | | | | | 155. Pollen | | | |
| 149. Measles | | | | | 156. Insect bites/scales | | | |
| 150. Venereal Disease | | | | | 157. Other: | | | |
| 151. Other: | | | | | | | | |
| | | | | | | | | |

Explanation of items checked "Yes." Enter item number (1-157) before each comment.

_____

_____

_____

_____

**B. CURRENT MEDICATIONS**: _____

_____

**C. SURGICAL HISTORY**

Have you ever had surgery? ☐ **Yes** ☐ **No**

*[If "Yes, complete the following information about each surgery]*

TYPE OF SURGERY DATE (Mo/Yr)

1. _____ _____
2. _____ _____

**D. HOSPITALIZATION HISTORY**

Have you ever been hospitalized? ☐ **Yes** ☐ **No**

*[If "Yes," complete the following information about each hospitalization.]*

REASON FOR HOSPITALIZATION DATE (Mo/Yr)

1. _____ _____
2. _____ _____
3. _____ _____