YOUTH SERVICES
OFFICE OF JUVENILE JUSTICE
PRE-EMPLOYMENT HEALTH HISTORY QUESTIONNAIRE

1. **YES** **NO** Are you currently under the care of a physician/health care provider?
   ____ ____ If **YES**, please answer the following:
   Physician/HCP treating you:
   ____________________________
   Diagnosis:
   ____________________________

2. Circle each item that you have had a problem with in the past (meaning since birth to present):

   **A. MUSCLES, BONES, AND JOINTS (Pain, sprain, fracture, dislocation, surgery):**
   - Neck
   - Upper back
   - Mid back
   - Lower back
   - Hip
   - Knee
   - Ankle
   - Foot
   - Shoulder
   - Elbow
   - Wrist
   - Hand
   - Fingers
   - Arthritis
   - Gout
   Provider comments:
   ____________________________

   **B. SKIN:** Itching Rash
   Provider comments:
   ____________________________

   **C. CHEST AND LUNGS:** Asthma Shortness of Breath
   Provider comments:
   ____________________________

   **D. NEUROLOGICAL:** Seizures/Epilepsy Fainting Blackouts Muscle weakness Paralysis Numbness Tingling in hands, feet or face
   Provider comments:
   ____________________________

   **E. HEART:** Heart problems? High Blood Pressure
   Provider comments:
   ____________________________

   **F. ENDOCRINE:** Diabetes Thyroid problems Any other endocrine problems?
   Provider comments:
   ____________________________

   **G. GASTROINTESTINAL (GI):** Any history of stomach/other GI problems? Hepatitis Hernia
   Provider comments:
   ____________________________

   **H. MENTAL HEALTH:** Any uncontrolled anxiety/depression/other problems?
   Provider comments:
   ____________________________

   **I. INFECTIONS:** Herpes infection of the finger? Cold sores Tuberculosis Hepatitis A B C (circle all)
   Provider comments:
   ____________________________

3. **YES** **NO** Do you have problems with latex gloves/other rubber products?
   ____ ____ If **YES**, please identify the product:
   ____________________________

4. **YES** **NO** Are there any other health conditions that you would like us to know about?
   ____ ____ If **YES**, please explain:
   ____________________________

5. **YES** **NO** Have you had the Chicken Pox/Varicella?
6. ____ **YES** **NO** Have you had the Measles?
7. ____ **YES** **NO** Have you had the Mumps?
8. ____ **YES** **NO** Have you had Rubella (3-day Measles)?
9. List Prescription Medications, Herbal Drugs and Over the Counter Medications that you are currently taking?
   ____________________________
   ____________________________
   ____________________________

10. List Allergies you have to food, drugs, pollens, chemicals, latex, etc:
   ____________________________
   ____________________________
   ____________________________

11. **YES** **NO** A. Have you ever been hospitalized?
    ____ ____ Explain:
    ____________________________
    ____________________________
A.2.61 (b)

B. Have you ever had surgery?
List year and type:

C. Do you have persistent (circle) upper back pain, mid-back pain, low back pain, neck pain, or arm pain?
If yes:
Do you now have pain:  Rarely  Occasionally  Frequently
• What is the longest period of time this bothered you?
• When was the last time you sought medical evaluation?
• __Yes  __No  Do you have any numbness/tingling/weakness in your arms or legs?  If yes, Where:
• __Yes  __No  Have you had surgery or seen a surgeon for this problem?

IMMUNIZATIONS:

Please respond Yes, No, or NS (Not Sure)

1. YES  NO  NS  Tetanus  Year: ____________ If yes, titer;  Year: ____________ Results: ____________
2. YES  NO  NS  Hepatitis B  Year: ____________
3. YES  NO  NS  Hepatitis A  Year: ____________
4. YES  NO  NS  MMR  Year: ____________ If yes, Rubella titer;  Results: ____________
5. YES  NO  NS  Varicella (Chicken Pox)  Year: ____________

PERSONAL HEALTH HABITS HISTORY:

1. YES  NO  Have you ever smoked?
2. __Yes  __No  Are you a current smoker?  If No, when did you quit?
3. __Yes  __No  Do you drink alcohol?  How much do you drink each week?

PAST WORK HISTORY:

1. Give your immediate past job title (Custodian, Administrative Assistant, Physician, etc)
Length of time in this position:  Years  Months
2. __Yes  __No  Have you ever been injured on the job in any way?  If yes, explain:
3. __Yes  __No  Have you ever received Workers Compensation benefits?

PAST WORK HISTORY:
4. __Yes  __No  Have you ever had to transfer from one job to another, or changed work duties because of health problems?

Applicant’s Signature: _________________________________________  Date: ______________________
Provider Signature: ___________________________________________  Date: ______________________