

Medical Questionnaire

All Florida Staffing, Inc.

Name of employee _____

Height _____

Social Security # _____

Weight _____

1. Do you now have, or have you ever had, any of the following?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (convulsions, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	Total deafness
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (medication? <input type="checkbox"/> yes <input type="checkbox"/> no)	<input type="checkbox"/>	<input type="checkbox"/>	Hyperinsulinaemia
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac (heart) disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Polio (poliomyelitis)	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Amputation of foot, leg, arm, or hand	<input type="checkbox"/>	<input type="checkbox"/>	Herniated intervertebral disk
<input type="checkbox"/>	<input type="checkbox"/>	Patellectomy (surgically removed kneecap)	<input type="checkbox"/>	<input type="checkbox"/>	Surgical removal of an intervertebral disk, or spinal fusion
<input type="checkbox"/>	<input type="checkbox"/>	Meniscectomy (inflammation of cartilage of certain joints-e.g. knee)	<input type="checkbox"/>	<input type="checkbox"/>	Surgical or spontaneous fusion of a major weight-bearing joint (frozen joint)
<input type="checkbox"/>	<input type="checkbox"/>	Total loss of sight of one or both eyes, or a partial loss of corrected vision of more than 75% bilaterally	<input type="checkbox"/>	<input type="checkbox"/>	One or more back or neck injuries or a disease process of the back or neck, substantiated by a doctor's opinion and resulting in disability over a total of 120 or more days
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	Obesity (30% overweight)
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis			
<input type="checkbox"/>	<input type="checkbox"/>	Ruptured cruciate ligament (knee ligament)			
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic osteomyelitis (infection in bone)			

2. Have you previously received workers' compensation for an on-the-job injury?
 yes no *if yes, did you have surgery?* yes no *if yes, please write why, when and where*
3. Have you ever received a disability rating or had one assigned to you by an insurance company or state/federal agency?
 yes no
4. Have you ever injured or sprained your back?
If yes, state percentage: _____%
 yes no *if yes, did you have surgery?* yes no *if yes, give details.*
5. Have you ever injured or sprained your neck?
 yes no *if yes, did you have surgery?* yes no *if yes, give details.*
6. Have you ever injured or sprained a knee?
 yes no *if yes, did you have surgery?* yes no *if yes, give details.*
7. Have you ever had any other type of surgery not mentioned above?
 yes no *if yes, did you have surgery?* yes no *if yes, give details.*
8. Do you have arthritis?
 yes no *if yes, what parts are affected?* _____
9. Are you on medication for arthritis?
 yes no

The information on this form shall not be used to discriminate against a qualified individual with a disability because of the existence of the disability in regard to the following: job application procedures; firing, advancement or discharge of the employee; employee compensation; job training; and other terms, conditions and privileges of employment.

Under penalty of perjury, I declare that I have read the foregoing and that the facts alleged are true to the best of my knowledge and belief.

Employee's signature _____

Date _____

Employer's signature _____

Date _____