Pre-Employment Medical History Form

Personal Information

Full Name

Date of Birth

Gender

Position Applied

Phone

Email

Address

Medical History

Do you have any history of the following? (If yes, please specify)

Condition	Yes/No	Details
Allergies		
Asthma		
Diabetes		
Epilepsy		
Heart Problems		
High Blood Pressure		
Other (please specify)		

Current Medications

List any medications you are currently taking:

Surgeries & Hospitalizations

Have you ever had any surgeries or been hospitalized? If yes, please provide details:

Lifestyle

Do you smoke?

Do you consume alcohol?

Additional Information

Is there any other health related information you wish to disclose?

Date

Signature