GRAND VIEW HEALTH

WORKPLACE HEALTH & WELLNESS

Workplace Health & Wellness
at Grand View Health
4 Lifemark Drive
Sellersville, PA 18960
215 453-4941

PHYSICAL HEALTH HISTORY FORM

Name: _____ DOB: _____

Medical History	Yes	No
1. Do you wear glasses or contact lenses?	☐	☐
2. Do you have any trouble with your eyes, ears, nose or throat?	☐	☐
3. Do you have any known heart disease, asthma, high or low blood pressure or history of blood clots?	☐	☐
4. Do you have any problems with your liver, stomach, bowels, ulcers, hemorrhoids or frequent upset stomach?	☐	☐
5. Do you have any trouble with your bladder or urinary tract?	☐	☐
6. Do you have any bladder or kidney infections?	☐	☐
7. Do you have diabetes, thyroid problems or hormonal disease?	☐	☐
8. Do you have any family history of diabetes, heart disease or cancer?	☐	☐
9. Do you have any skin problems?	☐	☐
10. Do you have any trouble with bones, tendons, muscles or joints?	☐	☐
11. Do you have any past or present back trouble?	☐	☐
12. Have you ever had any broken bones?	☐	☐
13. Did you ever have a rupture or hernia?	☐	☐
14. Did you ever have any nervous system disease or disorder?	☐	☐
15. Did you ever have fainting spells, blackouts, seizures or epilepsy?	☐	☐
16. Did you ever have any head injuries or concussions?	☐	☐
17. Have you ever had any severe infections?	☐	☐
18. Have you ever had any surgery or operations?	☐	☐
19. Have you ever had any serious injuries, bad burns or cuts?	☐	☐
20. Have you been hospitalized?	☐	☐
• If yes, where?		
• If yes, when?		
21. Did you have any illness, cold or flu in the past week?	☐	☐
22. Do you have allergies to medications, food (i.e., bananas, avocados, chestnuts, etc.) or latex?	☐	☐
• If yes, list any allergies below:		
23. Are you currently taking any medications for any reason?	☐	☐
24. Do you drink alcohol?	☐	☐
• If yes, how many drinks per week?		
25. Do you smoke or chew tobacco?	☐	☐
• If yes, how many packs per day?		
26. Do you use recreational drugs?	☐	☐

If you answered YES to any of the above questions, please explain below (include dates):

_____

_____

I CERTIFY THAT I HAVE ANSWERED THE QUESTIONS TRUTHFULLY REGARDING MY HEALTH HISTORY AND HAVE NOT KNOWINGLY WITHHELD ANY INFORMATION CONCERNING MY HEALTH STATUS EITHER PAST OR PRESENT. I UNDERSTAND THAT MY EMPLOYER WILL RECEIVE A "POST OFFER EVALUATION LETTER," WHICH WILL INDICATE MY ABILITY TO PERFORM THE ESSENTIAL FUNCTIONS OF MY JOB.

SIGNATURE: _____ **PROVIDER REVIEW INITIALS:** _____