HEALTH QUESTIONNAIRE

Instructions: Complete this form prior to your physical examination and give it to the examining physician at the time of examination. Answer all questions completely and accurately.

Leave this form (Health Questionnaire Form #BP-8 page 1 & 2) with the physician.

<u>DO NOT SUBMIT THIS FORM TO POST.</u>

Applicant's Name ***(last, first, middle)***		**Address**
Date of Birth	**Age**	**Current Occupation**

SECTION A: **Have you ever or do you now have any of the following? If you check "YES", supply full details in** SECTION B **on the reverse side. If the conditions required hospitalization, check the "HOSP" box.**

CONDITION	NO	YES	HOSP	CONDITION	NO	YES	HOSP
1. Head Injury	☐	☐	☐	**24. Sensitivity to Dust**	☐	☐	☐
2. Back Trouble or Back Pain	☐	☐	☐	**25. Other Allergies**	☐	☐	☐
3. Any Defect of Bones or Joints. Inc: Amputations, Dislocations, Broken Bones	☐	☐	☐	**26. Any Complications From Childhood Diseases**	☐	☐	☐
4. Lameness	☐	☐	☐	**27. Frequent Colds**	☐	☐	☐
5. Rheumatism or Arthritis	☐	☐	☐	**28. Cancer or Malignancy**	☐	☐	☐
6. Trick or Locked Knee/Knee Injury	☐	☐	☐	**29. Tumor, Growth or Cyst**	☐	☐	☐
7. Foot Trouble	☐	☐	☐	**30. Rheumatic Fever**	☐	☐	☐
8. Eye Injury, Surgery, Disease	☐	☐	☐	**31. Polio**	☐	☐	☐
9. Ever Worn Glasses or Contact Lenses	☐	☐	☐	**32. Pernicious Anemia, Leukemia, or Other Blood Disorder or Ailment**	☐	☐	☐
10. Hearing Impaired or Hearing Problems	☐	☐	☐	**33. Heart Trouble Including Circulatory**	☐	☐	☐
11. Ever Worn a Hearing Aid	☐	☐	☐	**34. High or Low Blood Pressure**	☐	☐	☐
12. Headaches	☐	☐	☐	**35. Hepatitis, Jaundice, or Other Blood Disorder or Ailment**	☐	☐	☐
13. Mental Illness or Nervous Breakdown	☐	☐	☐				
14. Addiction to Drugs or Alcohol	☐	☐	☐	**36. Diabetes or Sugar in Urine**	☐	☐	☐
15. Fainting or Dizzy Spells	☐	☐	☐	**37. Ulcers or Other Stomach Trouble**	☐	☐	☐
16. Epilepsy or Fits	☐	☐	☐	**38. Colitis**	☐	☐	☐
17. Any Disorder of the Nervous System	☐	☐	☐	**39. Gall Bladder Trouble**	☐	☐	☐
18. Tuberculosis or Other Lung Trouble	☐	☐	☐	**40. Kidney or Bladder Trouble**	☐	☐	☐
19. Shortness of Breath	☐	☐	☐	**41. Piles or Hemorrhoids**	☐	☐	☐
20. Asthma	☐	☐	☐	**42. Rupture or Hernia**	☐	☐	☐
21. Bronchitis	☐	☐	☐	**43. Mononucleosis**	☐	☐	☐
22. Poison Oak or Poison Ivy	☐	☐	☐	**44. Varicose Veins**	☐	☐	☐
23. Skin Trouble	☐	☐	☐	**45. Other:**	☐	☐	☐

HEALTH QUESTIONNAIRE

	NO	YES
46. Have you ever had or been advised to have an operation? If "YES" give the nature and date(s) of operation(s).	☐	☐
47. Have you ever been a patient (committed or voluntary) in a mental hospital? If "YES" give reasons, date(s) and place(s).	☐	☐
48. Have you had any other illness, injury, or physical condition not named above, other than childhood diseases or minor illness?	☐	☐
49. Have you had an injury within the last 5 years which caused you to lose time from work?	☐	☐
50. Have you ever been denied employment or insurance for medical reasons?	☐	☐
51. Have you ever been deferred from military service for medical, emotional, or health reasons?	☐	☐
52. Have you ever been discharged for released from employment or from the Armed Forces for medical, emotional, or health reasons?	☐	☐
53. Have you ever received or applied for pension or compensation for a disability or injury?	☐	☐
54. Are you presently under a doctor's care for any condition?	☐	☐
55. Have you taken medication within the last 12 months for any reason? If "YES" explain.	☐	☐
56. Do you have or have you ever had any physical or emotional limitations? If "YES" explain.	☐	☐
57. Do you have any impediments of your sense of smell? If "YES" explain.	☐	☐
58. Do you have any impediments of your sense of touch? If "YES" explain.	☐	☐

SECTION B: **Write your own account and explain all items answered "YES" in this questionnaire. Identify item by number, include diagnosis, date of onset, and your present condition. Continue on another piece of paper, as needed, and attach.**

Item ##	**Explanation (Attached additional pages to the back of this form if needed)**

CERTIFICATION: I hereby certify that there are no willful misrepresentations, omissions, or falsifications in the forgoing statements and answers to questions and that all statements and answers are true and correct to the best of my knowledge and belief.

I UNDERSTAND THAT I MUST LEAVE THE HEALTH QUESTIONAIRRE (Form BP-8 page 1& 2 and any attached supplemental pages) WITH MY PHYSICIAN.

Signature of Applicant ______________________________ **Date**__________________