Ashland
1247 E. Main St.
Ashland, OH 44805
PH: 419-281-2273
FAX: 419-207-1737

Ontario
68 Briggs Drive
Mansfield, OH 44906
PH: 567-247-2273
FAX: 419-529-0903

Companions
Nurse Aide Training Centers

Wooster
4164 Burbank Rd.
Wooster, OH 44691
PH: 330-601-1033
FAX: 330-601-1035

Orrville
516 W. High St.
Orrville, OH 44667
PH: 330-930-0136
FAX: 330-930-0137

EMPLOYEE HEALTH QUESTIONAIRE

Patient fills this side out ONLY

Name: _____ Marital Status: S / M / W / D

Sex: M / F Birthdate: _____ Phone:_____

Address: _____

Position: _____ Date: _____

Family Physician: _____

Date & Reason for last visit to Physician: _____

Family History: Nervous or Mental Illness: Y / N Diabetes: Y / N Tuberculosis: Y / N

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING: (Circle "Y" for Yes or "N" for No)

DISEASE OF:

1. Brain Y / N
2. Eyes Y / N
3. Ears Y / N
4. Nose Y / N
5. Throat Y / N
6. Heart Y / N
7. Lungs Y / N
8. Stomach Y / N
9. Intestines Y / N
10. Liver Y / N
11. Spleen Y / N
12. Gallbladder Y / N
13. Kidneys Y / N
14. Bladder Y / N
15. Bone Y / N
16. Joints Y / N
17. Back (Spine) Y / N
18. Skin Y / N
19. Lymph Y / N
20. Genitals Y / N
21. Dizziness Y / N
22. Frequent Headaches Y / N
23. Deafness Y / N
24. Ringing Ears Y / N
25. Frequent Sore Throat Y / N
26. Frequent Colds Y / N
27. Fainting Spells Y / N
28. Chest Pains Y / N
29. Shortness of breath Y / N
30. Chronic cough Y / N
31. Coughing up blood Y / N
32. Palpitations Y / N
33. Allergies Y / N
34. Poor appetite Y / N
35. Chronic indigestion Y / N
36. Recurrent nausea Y / N
37. Recurrent vomiting Y / N
38. Vomiting of blood Y / N
39. Chronic constipation Y / N
40. Black or bloody bowel movements Y / N
41. Frequent or painful urination Y / N
42. Blood in urine Y / N
43. Swollen Ankles Y / N
44. High blood Press. Y / N
45. Jaundice Y / N
46. Hernia (rupture) Y / N
47. Stomach ulcers Y / N
48. Pneumonia Y / N
49. Pleurisy Y / N
50. Kidney Stones Y / N
51. Piles Y / N
52. Convulsions Y / N
53. Bronchitis Y / N
54. Nephritis Y / N
55. Malaria Y / N
56. Rheumatic Fever Y / N
57. Paralysis Y / N
58. Cancer/Tumors Y / N
59. Asthma Y / N
60. Hay Fever Y / N
61. Arthritis Y / N
62. Rheumatism Y / N
63. Painful Flat Feet Y / N
64. Backaches Y / N
65. Chronic Sinus Infection Y / N
66. Injuries Y / N
67. Operations Y / N

WOMEN ONLY

68. Abnormal menstrual periods Y / N
69. PMS Y / N

Other serious illness which might affect your ability to perform the essential functions of the position offered. (please explain)

_____

Details of prior injuries or operations which might affect your ability to perform the essential functions of the position offered.

_____

What, if any accommodations do you feel would be required for you to perform essential functions of the position offered?

_____

I have read the above and declare that I have had no injury, illness or ailment other than as specifically here in noted. Any falsification or misrepresentation will be sufficient grounds for my release from employment/training. I give the examining physician permission to submit a report to the facility.

Signed: _____ Date: _____

Ashland
1247 E. Main St.
Ashland, OH 44805
PH: 419-281-2273
FAX: 419-207-1737

Ontario
68 Briggs Drive
Mansfield, OH 44906
PH: 567-247-2273
FAX: 419-529-0903

Companions
Nurse Aide Training Centers

Wooster
4164 Burbank Rd.
Wooster, OH 44691
PH: 330-601-1033
FAX: 330-601-1035

Orrville
516 W. High St.
Orrville, OH 44667
PH: 330-930-0136
FAX: 330-930-0137

PHYSICIANS HEALTH EXAMINATION
Pre-Employment/Training Physical Examination

Name: _____

Temp _____ Pulse _____ Resp _____ BP _____/_____ Weight_____ Height _____ft. _____in.

General Health:

_____

_____

Skin: _____

HEENT: _____

Neck: _____

Thorax/Lungs: _____

Heart: _____

Abdomen: _____

Nodes: _____

Musculoskeletal: _____

Vascular: _____

Neuro: _____

History or evidence of arthritis in any joints? _____

Any restrictions of his/her ability to lift residents? _____

Date _____ Physician's Signature _____

*WNL = within normal limits