ANNUAL PHYSICAL SELF ASSESMENT FORM

Name: ______________________________ Date: ______________________

Position: ____________________________ Department: ________________

Have you experienced any of the following disorders? (Circle Y or N)

High Blood Pressure	Y	N	Hepatitis	Y	N	Shortness of Breath	Y	N
Heart Trouble	Y	N	Dizziness	Y	N	Rupture of Hernia	Y	N
Rheumatic Fever	Y	N	Cancer	Y	N	Mental Disorder	Y	N
Arthritis	Y	N	Epilepsy	Y	N	Tumor	Y	N
Kidney Trouble	Y	N	Dislocations	Y	N	Skin Conditions	Y	N
Ulcers	Y	N	Broken Bones	Y	N	Anemia	Y	N
Diabetes	Y	N	Back Pain	Y	N	Sever Headaches	Y	N
Tuberculosis	Y	N	Back Injury	Y	N	Nervous Disorders	Y	N
Asthma	Y	N	Knee Injury	Y	N	Blood Disorders	Y	N
Hay Fever	Y	N	Head Injury	Y	N	Eye Trouble	Y	N
Allergies	Y	N	Varicose Veins	Y	N	Ear Trouble	Y	N
Gall Bladder Problems	Y	N						

Please explain all "Y" responses:

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Are you presently under a doctor's care for any reason?	Y	N
Are you taking any medication at this time?	Y	N
Do you have any bleeding or discharge?	Y	N
Are you pregnant?	Y	N
Have you ever had any operations?	Y	N
Are you a tobacco smoker?	Y	N
Do you drink alcohol and how much?	Y	N

Please explain all "Y" responses:

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Has anyone in your family had any of the following diseases or conditions? (Circle Y or N)

			Relation
Tuberculosis	Y	N	____________
High Blood Pressure	Y	N	____________
Diabetes	Y	N	____________
Kidney Disease	Y	N	____________
Epilepsy	Y	N	____________
Mental or Nervous Disorders	Y	N	____________

I believe, to the best of my knowledge, the above information to be true.

Employee Signature: ______________________________ Date: ______________