

STATE OF GEORGIA

Name: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MEDICAL AND PHYSICAL

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

**EXAMINATION PROGRAM**

**MEDICAL HISTORY REPORT** Job Category (circle one) 1 2 3 4 5

The purpose of these questions is to gather information concerning your health and physical condition, both now and in the past. This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered. Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave it blank and request assistance.

I certify under penalty of perjury, that the information given by me is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia, may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this medical history form.

EMPLOYEES' SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Individual History – To Be Completed By Applicant/Employee (Use Ink)**

**A. MEDICAL CONDITIONS.** Check every item. Do you have or have you ever had any of the following: (If "Yes," give date of most recent occurrence and explain on page 3.)

Health Condition	Yes	Year	No
<b>HEAD, NOSE, MOUTH AND THROAT</b>			
1. Persistent or severe headaches			
2. Frequent nose bleeds			
3. Frequent nasal congestion			
4. Persistent or severe sinus condition			
5. Bleeding gums			
6. Persistent or severe dental condition			
7. Hoarse when don't have cold			
8. Difficulty swallowing			
9. Persistent sore throat			
10. Loss of taste or smell			
11. Head injury			
12. Other head, nose, mouth or throat conditions:			
<b>EARS AND HEARING</b>			
13. Hearing difficulties			
14. Use hearing aid			
15. Ringing in ears (tinnitus)			
16. Perforated ear drum			
17. Persistent or severe ear infection			
18. Other ear or hearing conditions			
<b>EYES AND VISION</b>			
19. Glaucoma			
20. Cataract			
21. Eye irritations (itching or burning)			
22. Eye infection			
23. Defective vision			
24. Color blindness			
25. Injury to eye			
26. Eye surgery			
27. Double vision			

Health Condition	Yes	Year	No
28. Glasses			
29. Contact lenses			
<b>RESPIRATORY SYSTEM (lungs &amp; breathing)</b>			
30. Persistent or severe colds			
31. Persistent or severe cough			
32. Coughing blood			
33. Asthma or breathing difficulty			
34. Emphysema			
35. Pneumonia			
36. Tuberculosis			
37. Other lung or breathing condition:			
<b>CARDIOVASCULAR SYSTEM (heart &amp; blood vessels)</b>			
39. Heart attack			
39. Hardening of the arteries (Arteriosclerosis)			
40. High or low blood pressure			
41. Heart murmur			
42. Palpitations or irregular heart beat			
43. Episodes of chest pains, tightness, discomfort			
44. Shortness of breath			
45. Varicose veins			
46. Swelling of ankles, feet or legs (edema)			
47. Leg pains, cramps			
48. Other cardiac conditions:			
<b>GASTROINTESTINAL SYSTEM (stomach &amp; intestines)</b>			
49. Persistent or severe nausea or indigestion			
50. Persistent or severe stomach pain			
51. Vomiting blood			
52. Persistent or severe vomiting			
53. Hernia (rupture)			
54. Stomach or duodenal ulcer			

<i>Health Condition</i>	<i>Yes</i>	<i>Year</i>	<i>No</i>	<i>Health Condition</i>	<i>Yes</i>	<i>Year</i>	<i>No</i>
55. Colitis				99. Trick or locked knee			
56. Hemorrhoids or piles				100. Knee surgery			
57. Change in bowel habits				101. Foot problems			
58. Black stool or blood in stool				102. Bone infection			
59. Persistent or severe constipation				103. Broken or fractured bone			
60. Persistent or severe diarrhea				104. Persistent or severe muscle aches or pains			
61. Pancreatitis				105. Other Musculoskeletal conditions:			
62. Appendicitis				<b>ENDOCRINE/METABOLIC SYSTEM</b>			
63. Other conditions of stomach or intestines				106. Diabetes			
<b>LIVER, SPLEEN &amp; GALLBLADDER</b>				107. Thyroid condition or disease			
64. Cirrhosis				108. Hypoglycemia			
65. Hepatitis				109. Unexplained weight gain or loss			
66. Yellow jaundice				110. Unusual loss or growth of body hair			
67. Gallstones				111. Gout			
68. Other conditions of liver, spleen or gallbladder:				112. Osteoporosis or other bone disease:			
<b>KIDNEYS &amp; URINARY TRACT</b>				<b>SKIN</b>			
69. Kidney stones				113. Rash			
70. Kidney infection				114. Hives			
71. Blood or pus in urine				115. Moles that bleed or get larger			
72. Pain or burning when urinating				116. Change in color of skin (other than suntan)			
73. Frequent urination				117. Frequent boils/abscesses			
74. Albumen or protein in urine				118. Trouble with fingernails			
75. Prostate condition				119. Small itching blisters on the side of fingers or palms			
76. Burning discharge from penis				120. Sores that do not heal			
77. Other conditions of kidneys or urinary tract				121. Other skin conditions:			
<b>REPRODUCTIVE SYSTEM (FEMALES ONLY)</b>				<b>BLOOD/LYMPH (hematologic) SYSTEMS</b>			
78. Pregnant at present				122. Anemia			
<b>NEUROLOGICAL (Nervous) SYSTEM</b>				123. Bleeding disorder			
79. Epilepsy, convulsions, seizures				124. Sickle cell disease or trait			
80. Periods of blackouts/loss of consciousness				125. Phlebitis/blood clot			
81. Fainting spells				126. Blood transfusion			
82. Dizzy spells (vertigo)				127. Chills, fever, night sweats			
83. Memory difficulty				128. Lymph node or glandular swelling that persists			
84. Tremor of the hands or head				129. Other conditions of blood or lymph:			
85. Paralysis of any type				<b>CANCER</b>			
86. Stroke				130. Surgery			
87. Severe numbness, tingling or weakness				131. Radiation therapy			
88. Dyslexia/learning difficulty				132. Chemotherapy			
89. Other conditions of neurological (nervous) system:				133. Immunotherapy			
<b>MUSCULOSKELETAL SYSTEM</b>				134. Hormone therapy			
90. Arthritis				135. Breast			
91. Bursitis/tendonitis				136. Bone			
92. Swollen or painful joints				137. Skin			
93. Dislocations				138. Other			
94. Painful or trick shoulder				<b>PSYCHOLOGICAL/MOOD</b>			
95. Elbow problems				139. Mental problem requiring hospitalization			
96. Wrist or hand problems				140. Suicidal/attempted suicide			
97. Back pain				141. Active psychosis			
98. Back surgery				142. Drug, narcotic or alcohol			

Health Condition	Yes	Year	No	Health Condition	Yes	Year	No
143. Persistent or severe depression/worry				ALLERGIES (caused by)			
144. Other psychological conditions:				152. Medication			
INFECTIOUS OR CHILDHOOD DISEASES				147. Rheumatic fever			
145. Meningitis/encephalitis				153. Food			
146. Polio				154. Soaps or detergents			
148. Mumps				155. Pollen			
149. Measles				156. Insect bites/scales			
150. Venereal Disease				157. Other:			
151. Other:							

Explanation of items checked "Yes." Enter item number (1-157) before each comment.

---

**B. CURRENT MEDICATIONS:**

**C. SURGICAL HISTORY**

Have you ever had surgery?  Yes  No

*[If "Yes, complete the following information about each surgery]*

TYPE OF SURGERY	DATE (Mo/Yr)
1. _____	_____
2. _____	_____

**D. HOSPITALIZATION HISTORY**

Have you ever been hospitalized?  Yes  No

*[If "Yes," complete the following information about each hospitalization]*

REASON FOR HOSPITALIZATION	DATE (Mo/Yr)
1. _____	_____
2. _____	_____
3. _____	_____