

## EMPLOYEE HEALTH: PRE-VOLUNTEER HEALTH REVIEW

LAST NAME	FIRST NAME	MI	BIRTH DATE	AGE	SEX F M	ORIENTATION DATE	TODAY'S DATE
<b>VOLUNTEER</b>			<b>VOLUNTEER SRV</b>			<b>VOLUNTEER</b>	
POSITION/TITLE			DEPARTMENT			EMPLOYEE ID#. (to be provided by Employee Relations)	
ADDRESS (STREET/P.O. BOX)			CITY, STATE, ZIP			HOME #  CELL #	

### YOUR HEALTH HISTORY

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
1. FREQUENT/SEVERE HEADACHE			21. PALPITATION/POUNDING HEART			41. PAIN IN SHOULDER/ARM/HAND		
2. HEAD INJURY/CONCUSSION			22. HIGH BLOOD PRESSURE			42. CARPAL TUNNEL SYNDROME		
3. NECK INJURY/WHIPLASH			23. HEART FAILURE			43. TENDONITIS/BURSITIS		
4. RECURRENT NECK PAIN			24. KIDNEY STONE/BLOOD IN URINE			44. OVERUSE SYNDROMES		
5. DIZZINESS OR VERTIGO			25. SUGAR/ALBUMIN IN URINE			45. NUMBNESS OR WEAKNESS		
6. EPILEPSY/SEIZURES			26. DIABETES			46. PAIN IN HIP/KNEE/ANKLE/FOOT		
7. SLEEP DISORDER/PROBLEMS			27. LIVER DISEASE/JAUNDICE			47. HIP PROBLEMS		
8. VISUAL PROBLEMS			28. CHANGE IN BOWEL HABITS			48. KNEE PROBLEMS		
9. COLOR BLINDNESS			29. RECENT GAIN/LOSS OF WEIGHT			49. FOOT TROUBLE		
10. DOUBLE VISION OR BLINDNESS			30. ULCERS			50. SKIN TROUBLE, RASH OR DISEASE		
11. DO YOU WEAR GLASSES?			31. ANEMIA			51. SKIN DISORDERS		
12. DO YOU WEAR CONTACT LENSES?			32. HERNIA			52. DRAINING SORES OR WOUNDS		
13. DIFFICULTY HEARING			33. BACK PROBLEMS			53. ALLERGY TO LATEX OR RUBBER		
14. HEARING LOSS/HEARING AID			34. BACK STRAIN OR INJURY			54. RHEUMATIC FEVER		
15. RINGING IN EARS			35. BULGING/HERNIATED DISKS			55. SCARLET FEVER		
16. RECURRENT EAR INFECTIONS			36. SCIATICA/PINCHED NERVE			56. MEASLES		
17. SHORTNESS OF BREATH			37. BACK X-RAYS/MRI			57. MUMPS		
18. RECURRENT COUGH			38. BROKEN BONE OR BONE DISEASE			58. RUBELLA		
19. HEAT OR SUN STROKE			39. BONES OR JOINT DEFORMITY			59. CHICKEN POX		
20. CHEST PAIN OR PRESSURE			40. RHEUMATISM/ARTHRITIS			60. SHINGLES		

LIST OTHER CHRONIC ILLNESS OR INJURY

**COMMENTS FOR "YES" RESPONSES** (indicate the number with the comment):

ARE YOU TAKING MEDICATIONS?  Yes  No  
If yes, list:

ARE YOU ALLERGIC TO ANY MEDICATIONS?  Yes  No  
If yes, list:

### SURGICAL HISTORY

Please provide surgical information that is related to any of the above health history.

LIST PREVIOUS SURGICAL PROCEDURES (TYPE)	Year	Name and Location of Surgeon and Hospital	Complications, if any

