

NAME(LAST, FIRST AND MIDDLE)		DATE (MM/DD/YYYY)	
ADDRESS (STREET NO., APT.,CITY, STATE, ZIP)			TELEPHONE NO, (____) ____-____
SOCIAL SECURITY NUMBER	SEX	AGE	DATE OF BIRTH (MM/DD/YYYY)
JOB TITLE	HEIGHT ____ FT. ____ IN.		WEIGHT ____ LBS.

INSTRUCTIONS:
THIS FORM IS A PART OF THE APPLICATION PROCESS AND MUST BE COMPLETED.
PLEASE ANSWER ALL THE FOLLOWING QUESTIONS COMPLETELY AND TO THE BEST OF YOUR ABILITY.
MISSING, MISSTATING OR MISREPRESENTING FACTS ASKED FOR MAY BE THE BASIS FOR REFUSAL OF EMPLOYMENT OR TERMINATION FROM THE CITY. DO NOT SKIP ANY SECTION OR QUESTIONS.

SECTION A: MEDICAL HISTORY

Each of the questions below require a yes or no answer. If you are unsure or do not know the answer mark the unknown answer box in the box space provided. If you need additional space to explain a specific response to a question, use the area provided titled as "Additional Comments" on page three and state the number section along with explanation.

SYSTEM REVIEW OR MEDICAL CONDITION:	SYSTEM REVIEW OR MEDICAL CONDITION:
YES NO UNK	YES NO UNK
1. VISION/EYES	3. NOSE AND THROAT
Do you wear glasses?	Do you now or have you ever had the following:
For reading?	Chronic or persistent infections?
For distant vision?	Nasal fracture or injury?
Do you wear contact lenses?	Frequent nose bleeds?
Do you now or have you had any of the following:	Nose/Throat surgery?
Color Blindness?	Explain: _____
Abnormal night vision?	
Glaucoma?	4. CARDIOVASCULAR/ HEART& CIRCULATORY SYSTEM
Depth perception problems?	Do you now or have you ever had the following:
Other eye conditions or surgery?	Heart attack(s)?
Explain: _____	Date & Explain: _____
2. HEARING/EARS	
Do you have normal hearing?	Stroke(s)?
Do you now or have you had any of the following:	Date & Explain: _____
Some hearing loss?	
Serious ear infections?	Irregular or sudden rapid pulse?
Major injury affecting your hearing?	Abnormal electrocardiogram?
ringing in the ears?	Heart murmur?
Recurring dizziness?	Swelling of the Ankles?
Ear Surgery?	Chest pain?
Explain: _____	High blood pressure?
	Congenital heart defects?

SYSTEM REVIEW OR MEDICAL CONDITION:				SYSTEM REVIEW OR MEDICAL CONDITION:			
YES NO UNK				YES NO UNK			
4. CARDIOVASCULAR/ HEART& CIRCULATORY SYSTEM CONTINUED...				7. ABDOMINAL ORGANS CONTINUED...			
Other heart or circulatory condition?				Hypoglycemia (low blood sugar)			
Explain: _____				Hernia?			
_____				Frequent urination?			
Heart surgery?				Pain in testicles?			
Explain: _____				Abdominal surgeries?			
_____				Explain: _____			
5. RESPIRATORY				8. BONE AND JOINT			
Do you now or have you ever had the following:				Do you now or have you ever had the following:			
Tuberculosis?				Arthritis or rheumatism			
Unusual shortness of breath?				(swelling or pain in joints)?			
Asthma?				Fractures or broken bones?			
Emphysema?				Explain: _____			
Chronic or persistent cough?				_____			
Frequent colds?				Disc problems (back/neck)?			
Coughed up blood?				Explain: _____			
Other lung disease?				_____			
Explain: _____				Chronic or persistent back pain?			
_____				Explain: _____			
Chest surgery?				Other back problems or surgery?			
Explain: _____				Explain: _____			
_____				_____			
6. SKIN				9. ALLERGIES			
Do you now or have you ever had the following:				Do you now or have you ever had the following:			
Chronic or persistent rash?				Knee problem?			
Sensitivity to sun?				Explain: _____			
Sensitivity to chemicals?				_____			
Infections?				Knee surgery?			
Skin tumors?				Explain: _____			
_____				_____			
7. ABDOMINAL ORGANS				Any other joint problems?			
Do you now or have you had any of the following:				Explain: _____			
Frequent nausea?				_____			
Frequent vomiting				Any other joint or bone surgery?			
Frequent indigestion or heartburn?				Explain: _____			
Frequent colitis?				_____			
Frequent diarrhea?				9. ALLERGIES			
Kidney or bladder disease or stones?				Do you now or have you ever had the following:			
Hepatitis, jaundice or other liver disease?				Hay fever or seasonal allergies?			
Gall bladder problems or stones?				Medication(s) allergies?			
Disease of the pancreas?				Explain: _____			
Diabetes (high blood sugar)				_____			

SYSTEM REVIEW OR MEDICAL CONDITION:	SYSTEM REVIEW OR MEDICAL CONDITION:																																												
YES NO UNK	YES NO UNK																																												
<p>11. OTHER MEDICAL FACTORS CONTINUED...</p> <p>Are you taking any medications either: prescribed? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, explain: _____</p> <hr/> <p>over the counter? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>f yes, explain: _____</p> <hr/> <p>Do you have specific medical condition(s) that prevent you from working in:</p> <p>a. Extreme heat? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>b. extreme cold? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, explain: _____</p>	<p>12. GENERAL INFORMATION CONTINUED...</p> <p>Work in remote, isolated or confined spaces? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Maintain your balance? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Perform strenuous physical activities? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>																																												
<p>12. GENERAL INFORMATION</p> <p>Have you been absent from work or school due to illness for more than 30 consecutive calendar days?</p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, please explain _____</p> <hr/> <p>Were you discharged from the military for medical reasons?</p> <p style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, please explain _____</p> <hr/> <p>Are you able to do the following activities:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 70%;">maintain a strong grip?</td><td style="width: 10%;"><input type="checkbox"/></td><td style="width: 10%;"><input type="checkbox"/></td><td style="width: 10%;"><input type="checkbox"/></td></tr> <tr><td>hold on to objects firmly?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>utilize your arms and shoulders to full capacity?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>stand and walk?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>squat or kneel?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>climb stairs?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>work on ladders or scaffolding?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>walk on slippery or uneven work surfaces?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>hold your head in a fixed position for prolonged periods of time?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Bend your back frequently?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>lift and carry objects of 50lbs or less?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	maintain a strong grip?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hold on to objects firmly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	utilize your arms and shoulders to full capacity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	stand and walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	squat or kneel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	climb stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	work on ladders or scaffolding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	walk on slippery or uneven work surfaces?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hold your head in a fixed position for prolonged periods of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bend your back frequently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lift and carry objects of 50lbs or less?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
maintain a strong grip?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
hold on to objects firmly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
utilize your arms and shoulders to full capacity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
stand and walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
squat or kneel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
climb stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
work on ladders or scaffolding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
walk on slippery or uneven work surfaces?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
hold your head in a fixed position for prolonged periods of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
Bend your back frequently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										
lift and carry objects of 50lbs or less?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																										

ADDITIONAL COMMENTS:

DECLARATION AND RELEASE

I declare that the foregoing statements are true to the best of my knowledge. I understand that leaving out or misrepresenting the facts called for in this questionnaire will be considered a willful omission. I also understand that any untruthfulness may be the cause for withdrawal of the offer of employment, termination or indefinite suspension from the City.

I hereby authorize the City at anytime to investigate or verify the facts claims by me on this questionnaire. I understand that I may be asked to provide additional information from my Primary Care or Attending Physicians as to any condition indicated herein. I hereby grant permission to the examining medical personnel and/or physician to disclose any information herein and hereinafter furnished by me, to authorize City personnel for purpose related to my employment with the City of Houston.

I understand that the physical examination given to me is only intended to obtain information for employment purposes at the City of Houston. It is not a physical examination of the type given by a physician to assess the state of my health and it may not be relied upon by me for that purpose. I must look to my personal physician for such assessment.

Signature

Date