DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
Division of Environmental Health
REPORT OF MEDICAL HISTORY

NAME:______________________________ SEX:_______ CITIZENSHIP:__________
LAST FIRST MIDDLE

DATE OF BIRTH:____________ PLACE OF BIRTH:_______________ ETHNICITY:___________

Name of Business Applied For:______________________________ LOCATION:____________

Please complete this form and take it with you to your physician for examination.

PERSONAL HISTORY

Please indicate YES or NO in all questions. Make appropriate comments in the space provided below or on a separate sheet of paper.

Have you had	YES	NO	Have you had	YES	NO	Have you had	YES	NO	Comments
SCARLET FEVER			PAIN IN CHEST			INSOMNIA (can't sleep)			
RHEUMATIC FEVER			SHORTNESS OF BREATH			ANXIETY WORK			
MEASLES			HEART ATTACKS/STROKE			DEPRESSION			
GERMAN MEASLES			ALLERGY			NERVOUSNESS			
MUMPS			TUBERCULOSIS			STOMACH TROUBLE			
CHICKEN POX			TUMOR			DIARRHEA			
MALARIA			ASTHMA			DIZZINESS/FAINTNESS			
RECENT WEIGHT GAIN/LOSS			HAY FEVER			PALPITATION			
ANY SURGERY			CANCER			HEADACHES			
BACK INJURY			JAUNDICE			COLDS/SORE THROAT			

SMOKING (Current/Specify packs per day:_______________ **Alcohol Use (Estimate Intake):____________**

Have you or any of your immediate family ever had any of the following conditions:

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
TUBERCULOSIS				KIDNEY DISEASE			
DIABETES				HIGH BLOOD PRESSURE			
ARTHRITIS				STOMACH AILMENT			
EPILEPSY				ASTHMA/HAY FEVER			
CONVULSIONS				SKIN DISEASE			
HEART DISEASE				OTHER DISEASE(S)			

FAMILY HISTORY

Family Member	Age	State of Health	Age at Death	Cause of Death	Family Member	Age	State of Health	Age at Death	Cause of Death
FATHER					MOTHER				
BROTHER					SISTER				
BROTHER					SISTER				
BROTHER					SISTER				

PHYSICIAN'S CERTIFICATION

I hereby certify based upon my examination of ______________________________ on ____________, that
Last First Middle Initial Date

( ) FREE FROM INFECTIOUS DISEASE AND IN GOOD HEALTH

( ) IN POOR HEALTH BUT ABLE TO MAINTAIN EMPLOYMENT

( ) IN POOR HEALTH AND UNABLE TO MAINTAIN EMPLOYMENT

/ / Temporary / / Permanently / / Other: (Pls. state duration) From____________
To____________

Activities to be avoided: / / Lifting / / Pushing / / Standing / / Climbing / / Walking

/ / Other:____

For DEH Use Only

____
PHYSICIAN SIGNATURE

____
CLINIC OR HOSPITAL

Date:________________