



## CITY OF KINSTON MEDICAL ID HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_ Position: \_\_\_\_\_ Dept: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

<i>Do you have or ever had:</i>	<i>Yes</i>	<i>No</i>	<i>Explain Yes</i>
<i>Heart trouble, asthma</i>			
<i>High Blood Pressure</i>			
<i>Fits, convulsions, epilepsy</i>			
<i>Fainting spells/dizziness</i>			
<i>Frequent/severe headaches</i>			
<i>Head injury, loss of consciousness</i>			
<i>Trouble with back, neck, spine, disk</i>			
<i>Broken bones, dislocated joints</i>			
<i>Arthritis, swelling, joint pain</i>			
<i>Skin trouble, eczema, rash</i>			
<i>Varicose veins/leg sores</i>			
<i>Shortness of breath, chest tightness</i>			
<i>Wheezing, recurring cough</i>			
<i>Tuberculosis, coughing blood</i>			
<i>Bronchitis, emphysema, lung disease</i>			
<i>Nervous/mental disorder</i>			
<i>Diabetes, sugar in urine</i>			
<i>Kidney/Bladder problems</i>			
<i>Albumin/Blood in urine</i>			
<i>Hearing difficulty/ aids</i>			
<i>Eye trouble, glasses</i>			
<i>Allergies, drug reaction</i>			
<i>Cancer/tumor/hernia</i>			
<i>Stomach/Duodenal ulcer</i>			
<i>Trouble with stomach/bowels</i>			
<i>Hemorrhoids, blood in stool</i>			
<i>Trouble with liver, Hepatitis</i>			
<i>Anemia, Leukemia, Blood Disease</i>			
<i>Operations</i>			
<i>Other conditions not mentioned</i>			
<b>HAVE YOU EVER:</b>			
<i>Worked in a dusty trade</i>			
<i>Worked with chemicals/fumes</i>			
<i>Are you currently receiving medical treatment</i>			

The above statements are true to the best of my knowledge. I understand that any misstatement of fact is grounds for dismissal.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_