Name: _____ PFC Associates Date: _____

SSN: _____ Applicant Medical Questionnaire

DOB: _____

PAST MEDICAL HISTORY: Check any of the following conditions that you have now or have ever had:

HEAD	YES	NO
Injury	___	___
Loss of Consciousness	___	___
Seizure	___	___
Dizziness	___	___
Fainting	___	___
Chronic Headaches	___	___
Migraines	___	___

EARS	YES	NO
Injury	___	___
Ringing	___	___
Decreased Hearing	___	___
Hearing Loss	___	___
Ruptured Ear Drum	___	___

EYES	YES	NO
Injury	___	___
Double Vision	___	___
Blurred Vision	___	___
Glasses	___	___
Contacts	___	___
Decreased Far Vision	___	___
Decreased Near Vision	___	___
Vision in One Eye	___	___
Color Vision Disorder		

THROAT	YES	NO
Injury	___	___
Chronic Sore Throats	___	___
NECK		
Injury	___	___
Masses	___	___

MUSCULOSKELETAL	YES	NO
Joint Pain	___	___
Muscle Weakness	___	___
Arthritis	___	___
Back Injury or Pain	___	___
Back Surgery	___	___
Herniated Disk	___	___

FRACTURES OR INJURY	YES	NO
Shoulder	___	___
Elbow	___	___
Wrist	___	___
Hand	___	___
Fingers	___	___
Hip	___	___
Knee	___	___
Ankle	___	___
Foot	___	___
Other Joint	___	___

NEUROLOGICAL		
Tremors	___	___
Numbness/Weakness	___	___
Confusion	___	___
Dizziness	___	___
Convulsions	___	___

CARDIOVASCULAR	YES	NO
Chest Pain/Tightness	___	___
Heart Attack	___	___
Palpitations	___	___
Irregular Heart Beat	___	___
High Blood Pressure	___	___
Stroke	___	___
Heart Murmur	___	___

	YES	NO
DIABETES	___	___
THYROID DISORDER	___	___
CANCER	___	___
BLEEDING DISORDER	___	___
ANEMIA	___	___

PULMONARY DISORDERS	YES	NO
Asthma	___	___
Shortness of Breath	___	___
Lung disease/problems	___	___
NOSE DISORDERS		
Injury	___	___
Chronic Nose Bleeds	___	___
SINUS DISORDERS		
Allergies	___	___

ABDOMEN	YES	NO
Chronic Abdominal Pain	___	___
Abdominal Cramps	___	___
Diarrhea	___	___
Nausea/Vomiting	___	___
Bowel Problems	___	___
Hepatitis	___	___
Hernia	___	___

KIDNEY	YES	NO
Injury	___	___
Bladder Disorders	___	___
Kidney Disorders	___	___
Dark Urine	___	___

MENTAL	YES	NO
Memory Loss	___	___
Depression	___	___
Phobias (including Claustrophobia)	___	___
Suicidal	___	___
Homicidal	___	___
Anxiety	___	___
Posttraumatic Stress Disorder	___	___
Decrease Alertness		
Unexplained Sleepiness		

SKIN	YES	NO
Rash	___	___
Jaundice	___	___

PLEASE TURN PAGE OVER AND ANSWER QUESTIONS

ANSWERS TO YES: EXPLAIN (including dates and treatments)

PLEASE LIST ANY

Hospitalizations, Operations, Injuries or Illness	Year

PLEASE LIST THE LAST TIME YOU HAD

Hepatitis Vaccine _____ Have you had the 3-shot series? YES___ NO___
T.B. Test _____
Tetanus Shot _____
History of Positive T.B. Test, YES___ NO___Treatment Dates: _____

HAVE YOU HAD

Chicken Pox Yes_____ No_____ Date:_____
Mumps Yes_____ No_____ Date:_____
Measles Yes_____ No_____ Date:_____

Social History

Have you ever smoked? Yes_____ No_____ Packs per Day_____Years_____

Do you drink alcohol? Yes_____ No_____ How much?_____

LIST ALL MEDICATIONS

Medication	Dose	# Times Per Day

Drug Allergies

I certify to the best of my knowledge that the above answers are correct and complete.

X _____

Applicant Signature and Date