O **M** **S**

144 Valhi Lagoon Crossing Houma, LA 70360 Phone 985.223.0032 Fax 985.872.6670

Applicant: _____ Date: _____

Address: _____ D.O.B. _____ Tel # _____

Position Applied for: _____ S.S.# _____

Medical Questionnaire

Circle Y for YES and N for NO if you currently have the following symptoms or have significantly in the past.

Poor Vision	Y N	Carpal Tunnel Syndrome	Y N	Thyroid problems	Y N
Color Blindness	Y N	Stomach Problems	Y N	Colitis	Y N
Cataract	Y N	Bloody bowel movements	Y N	Sleep Apnea	Y N
Glaucoma	Y N	Wear glasses or contacts	Y N	Hepatitis	Y N
Ear Infection	Y N	Epilepsy/seizures	Y N	Cancer or Tumors	Y N
Hearing Aid	Y N	Migraine Headache	Y N	ANY SURGERY?	Y N
Loss of Hearing	Y N	Loss of Consciousness	Y N	Concussion or head injury	Y N
Dental problems/TMJ	Y N	Dizziness/Vertigo	Y N	Been a patient in a hospital	Y N
Allergies	Y N	Peripheral Nerve Disease	Y N	Cirrhosis	Y N
Tuberculosis	Y N	Frequent worry/depression	Y N	Had a hernia	Y N
Asthma & Breathing difficulties	Y N	Kidney trouble/stones	Y N	Had fits or fainting	Y N
Lung collapse	Y N	Bladder/Gallbladder Trouble	Y N	Had a serious illness	Y N
Shortness of breath/wheezing	Y N	Difficult or frequent urination	Y N	Broken a bone	Y N
Emphysema	Y N	Venereal disease	Y N	Missing any limbs	Y N
Irregular heart beat	Y N	Irregular period/menstruation	Y N	Injured your neck or experienced back pain	Y N
Varicose Veins	Y N	Are you pregnant?	Y N	Injured your neck or experienced neck pain	Y N
Stroke	Y N	Date of last pap smear	_____	Injured your right or left hip	Y N
Leg Ulcers	Y N	Date of last mammogram	_____	Injured your right or left shoulder	Y N
Anemia	Y N	Prostate problems	Y N	Injured your right or left leg	Y N
Leukemia	Y N	HIV Positive	Y N	Injured your right or left knee	Y N
Diabetes	Y N	Sickle Cell Disease	Y N	Injured your right or left ankle	Y N
High Blood Pressure	Y N	Rash/Dermatitis	Y N	Injured your right or left foot	Y N
Heart Disease	Y N	Psoriasis	Y N	Received worker's compensation	Y N
Mental Illness	Y N	Dislocations	Y N	Received disability benefits	Y N

Undergone an MRI, CT Scan, Discogram or Myelogram for any part of your body?	Y N
Received a disability rating from a physician resulting from any injury to any part of your body?	Y N
Been limited in the amount of weight you can lift by a physician?	Y N
Failed a physical or denied employment due to any injury or illness?	Y N
Are your presently taking a prescriptive medication?	Y N
Have you EVER had an illness, injury, or claim arising out of your employment?	Y N

Please fully describe any "yes" responses; (Back Surgery 1-26-94 injury on job etc.)

_____

_____

Are you currently unable to perform any activity or do you have any lifting restrictions? Y N List: _____

Present Medication: _____

Have you ever had an injury which required you to miss time from work? Yes No

If yes, give dates, nature of claim, and outcome. _____

_____

_____

_____

Warning: Pursuant to LSA-RS 23:1208.1, I understand that failure to answer truthfully any/all of the above questions of this medical questionnaire may result in a denial of any right I or my dependants may have to workers compensation benefits, including medical treatments and expenses. I have read and fully understand the above. **(Initial) _____**

Signature of Applicant _____