ORLEANS COUNTY SELF-ASSESSMENT HEALTH FORM

NAME: _____ MUNICIPALITY: _____

1. Sex ☐ Male ☐ Female 2. Birth Date (mo./day/yr.) ___/___/___ 3. Height (without shoes) _____
4. Weight (with indoor clothing) _____ lbs. 5. Blood Pressure (at last check) ___/___ ☐ do not know
6. Has your blood pressure been checked within the last year ☐ yes ☐ no
7. Blood Cholesterol Level _____ ☐ do not know
   ☐ do not know exactly, but it is < 220
   ☐ do not know exactly, but it is > 220
8. Have you ever smoked? ☐ no, I have never smoked
   ☐ yes, I used to smoke but I do not now
   ☐ yes, I now smoke fewer than 20 cigarettes a day
   ☐ yes, I now smoke 20 or more cigarettes a day
   ☐ yes, I now smoke a pipe or cigars
9. Have you ever been told by a doctor or nurse that you had any of the following?

	Yes	No		Yes	No	
Heart Disease	☐	☐	Diabetes	☐	☐	
Stroke	☐	☐	Cancer (where)	☐	☐	_____
Hypertension	☐	☐	Tuberculosis	☐	☐	

10. Have either of your parents, your parents siblings, or your own siblings had any of the following?

	Yes	No		Yes	No	
Heart Disease	☐	☐	Diabetes	☐	☐	
Stroke	☐	☐	Cancer (where)	☐	☐	_____
Hypertension	☐	☐	Tuberculosis	☐	☐	

11. Please fill in the dates when you last had the following:

Illness	Date	Immunization for:	Date
Measles	_____	**Tetanus**	_____
Mumps	_____	Diphtheria	_____
Whooping Cough	_____	Polio	_____
Chicken Pox	_____	Measles	_____
Rheumatic Fever	_____	Mumps	_____
Polio	_____	Rubella	_____
Scarlet Fever	_____		
Rubella	_____		

Tests and Exams	Date	Result
Rubella titre	_____	_____
TB Test	_____	_____
Chest X-ray	_____	_____
TB Test	_____	_____
Dental Exam	_____	_____
Vision Exam	_____	_____
Glaucoma Test	_____	_____
EKG (electro-cardiogram)	_____	_____
Physical Exam	_____	_____

12. Who is your regular physician?_____

NAME: _____ MUNICIPALITY: _____

13. Please list operations and hospitalizations you have had.

Type / Reason	Date	Where	Physician

14. Please list prescriptions and non-prescription medications you now take.

Medication	Dosage	Frequency Taken	Why Taken

15. Please list any allergies you have:

_____

Please check any of the following that you have had or which has been a persistent problem for you, and briefly explain the circumstances:

	Explain		Explain
☐ Rashes	_____	☐ Poor appetite	_____
☐ Itching	_____	☐ Stomach pain	_____
☐ Change in skin color	_____	☐ Frequent nausea	_____
☐ Headaches	_____	☐ Frequent diarrhea	_____
☐ Head Injury	_____	☐ Blood in stool	_____
☐ Glasses or Contacts	_____	☐ Yellow skin	_____
☐ Redness in eyes	_____	☐ Painful urination	_____
☐ Cataracts	_____	☐ Frequent urination	_____
☐ Glaucoma	_____	☐ Blood in urine	_____
☐ Double Vision	_____	☐ Kidney stone	_____
☐ Hearing problem	_____	☐ Joint stiffness	_____
☐ Earache	_____	☐ Muscle cramps	_____
☐ Ear infection	_____	☐ Back pain	_____
☐ Discharge from ear	_____	☐ Back injury or surgery	_____
☐ Nosebleeds	_____	☐ Joint injury or sprain	_____
☐ Sinus trouble	_____	☐ Broken bone	_____
☐ Hay fever	_____	☐ Weakness	_____
☐ Frequent colds	_____	☐ Seizures	_____
☐ Sore tongue	_____	☐ Dizziness	_____
☐ Hoarseness	_____	☐ Convulsions	_____
☐ Dental problems	_____	☐ Tremors	_____
☐ Frequent cough	_____	☐ Numbness	_____
☐ Wheezing	_____	☐ Epilepsy	_____
☐ Asthma	_____	☐ Bruise easily	_____
☐ Bronchitis	_____	☐ Anemia	_____
☐ Emphysema	_____	☐ Intolerance to heat	_____
☐ Pneumonia	_____	☐ Intolerance to cold	_____
☐ Tuberculosis	_____	☐ Excessive thirst	_____
☐ Heart trouble	_____	☐ Excessive sweating	_____
☐ High blood pressure	_____	☐ Problems with menstruation	_____
☐ Heart murmur	_____	☐ Swelling of legs or feet	_____
☐ Irregular heart beat	_____	☐ Stroke	_____

NAME: _____ JOB TITLE: _____

Social Security Number: _____-_____-_____

☐ COUNTY ☐ TOWN ☐ VILLAGE ☐ VOLUNTEER FIRE DEPARTMENT

MUNICIPALITIES NAME: _____

DEPARTMENT: _____ FIRST DAY OF WORK ___/___/___

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Home Telephone Number: (_____) _____-_____

COMPENSATION STATEMENT

PREVIOUS WORKERS'COMPENSATION CLAIMS:

Have you ever missed work due to a job related injury or illness? ☐ yes ☐ no

If yes, please explain the nature of the injury or illness and state how many days of work missed during each of the last five (5) years due to the job related injury or illness.

State	Name of employer	Description of Injury	Date of Injury	Name of Doctor	Type of Treatment	Number of Days Missed

Current status of problems(s):

THIS AFFIRMATION MUST BE COMPLETED

I affirm that the statements made on this Orleans County Self-Assessment Health Form (including any attached papers) are true under the penalties of perjury.

_____ _____
Signature Date

11/01/2008

(To be completed by Self Insurance Department)

Comments of interviewer:

Review summary _____ No follow-up _____ Signature of Reviewer _____

More information needed _____ Required further investigation _____

Letter and clinic schedule _____ Date reviewed _____ 12/01/2008