Printable Health Assessment Form

Name: _____ Date of Birth: _____

Gender: _____ Employee No. _____ Position: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____ Fax: _____

I. Medical conditions

Please indicate **TRUE** or **FALSE** in the spaces to the right of the statement

Heart Failure _____ Hypertension _____

Angina _____ Hypercholesterolemia _____

Emphysema _____ Asthma _____

Allergic rhinitis _____ Diabetes _____

Thyroid disease _____ Esophagitis _____

Duodenal, stomach or Peptic ulcer _____ Glaucoma _____

Colitis and Crohn's disease _____ Seizures _____