Niagara Falls City School District
Health Services

Health History Form for New Employees

Name:	**DOB:**
Position applying for	**Gender:**
Address:	**Phone #:**
Medical Provider:	

HEALTH HISTORY								
Check the appropriate box:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Skin			**Infectious Diseases**			Pacemaker		
Lesions/Rashes			Mononucleosis			Defibrillator		
Neurological			Poliomyelitis			Varicose veins		
Headaches			Hepatitis			**Gastrointestinal**		
Migraine			**Hematology**			Jaundice		
Head Injuries			Bleeding disorders			Gall bladder		
Concussions			Transfusions			Stomach Disorders		
Seizure disorders/			Anemia			Diverticulosis		
Fainting/blackouts			**Endocrine**			Ulcers		
Paralysis/numbness			Diabetes			Indigestion		
Eye Problems			Hypoglycemia			Chronic Colitis		
Vision loss			Thyroid conditions			Hernia		
Amblyopia			Fatigue			**Musculoskeletal**		
Glaucoma			Night sweats			Arthritis		
Glasses/Contact lenses			**Lung/Respiratory**			Joint/back Problem		
Ears/Nose/Throat			Asthma			Facture bone		
Haring loss			Allergies			Dislocation		
Chronic ear infections			Pneumonia			Scoliosis		
Tinnitus (ears ringing)			Bronchitis			Sprain/recurrent injury		
Sinus problems			Tuberculosis			Physical disability		
Frequent nose bleeds			Emphysema			**Other**		
Nose fracture/surgery			**Cardiovascular**			Cancer		
Chronic tonsillitis/strep			Heart Murmur			Drug/Alcohol abuse		
Hoarseness			Hypertension			Mental Illness		
Tonsils/adenoids removed			Heart Disease			Anxiety		
Dental			Rheumatic Fever			Depression		
Bleeding gums			Heart Surgery			Speech Problems		
Explain _____			Bypass					
Genitourinary			**Genitourinary**			**Genitourinary**		
Male Only			***Female Only***			***Female Only Cont.***	Date	
Testicle injury/surgery			Bladder problems			Last Pap Smear		
Prostate Problem			Menstruation Problems			Last mammogram		
Change in Urination Pattern			Pregnancy Complications			Last Menstrual Period		

See Reverse to continue:

Niagara Falls City School District
Health Services

Please Explain all "YES" answers form side 1 here

_____
_____
_____
_____

Have you:
Ever been a patient in a hospital or had out-patient surgery? Explain _____
_____
_____
Had any injuries from an accident (i.e. MVA, falls, work related)? Explain _____
_____
_____
Are you under a Health Care Providers care now? Explain _____
_____
_____
Are you taking any Medications? Please List Here: _____
_____
_____
Are you allergic to any Medications? _____
If you have limited physical activity _____ Yes _____No
Explain (ie unable to do stairs, lift, sit or stand for long periods _____
Are you able to lift, push or pull at least 50 lbs? _____ Yes _____No
Is there any significant family medical history? _____
_____
_____

ANSWERING THE FOLLOWING QUESTIONS IS STRICTLY VOLUNTARY. THE INFORMATION ASKED FOR IS KEPT CONFIDENTIAL AND IS USED ONLY TO HELP YOU AND THE MEDICAL STAFF BEST ASSESS FOR YOUR HEALTH AND/OR HEALTH NEEDS. AND ONLY NEEDED IF YOU DO NOT HAVE A MEDICAL PROVIDER TO COMPLETE YOUR PHYSICAL EXAM.

Do you Drink:

Coffee with caffeine?	**_____**	**Drinks per day _____**
Tea with caffeine?	**_____**	**Drinks per day _____**
Other drinks with caffeine?	**_____**	**Drinks per day _____**
Alcohol?	**_____**	**Drinks per day _____ Per week ____ Per month _____**

Do you use:

Cigarettes?	**_____**	**Packs per day _____**
Vaping?	**_____**	**Vapes per day _____**

Candidates Signature _____ Today's Date _____

Return this form directly to: **Niagara Falls City School District**
C/O Nurse Practitioner Office
4455 Porter Rd., Room 110
Niagara Falls, New York 14305
Phone: 716-286-0788 or 716-286-0787 **FAX: 716-286-0758**

Niagara Falls City School District

Health Services

Physical Examination Form for New Employees

Name:	**DOB:**
Address:	**Phone #:**

PAST MEDICAL HISTORY								
Check the appropriate box:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Allergies			Fatigue			Mental illness		
Arthritis			Fevers/night sweats			Migraine headache		
Asthma/respiratory problems			Glaucoma			Physical disability		
			Hearing problems			Seizures		
Back problems			Heart Disease			Sinus problems		
Bleeding gums			Heart Murmur			Skin disorder		
Cancer			Hypertension			Speech problems		
Concussion(s)			Indigestion			Strep throat		
Diabetes			Kidney problems			Tuberculosis		
Drug/Alcohol abuse						Visual problems		

Serious illness/injury in past 3 years: (specify dates)	
Past surgical history:	
Current medications:	

REQUIRED IMMUNIZATIONS (Birth – Five Program)	**Date**	**Results**
Tuberculin Test (Mantoux)		☐Negative ☐Positive
Diphtheria Tetanus (DT)		N/A

PHYSICAL EXAMINATION		Height:	Weight:	BP:	Pulse:
Visual acuity	Right:	Left:		Peripheral Vision:	
Hearing acuity	Right:	Left:		Color Blind?	☐Yes ☐No
REVIEW OF SYSTEMS:					
Head:		Ears:		Nose:	
Throat/neck:		Cardiovascular:		Respiratory:	
Abdomen:		GU:		Musculoskeletal:	
Metabolic/Endocrine:		Skin:		Extremities:	
URINALYSIS: Sugar:		Protein:			

I hereby certify that I have examined the above named applicant and find he/she is physically qualified for lawful employment:

Medical Provider:_____ _____

(please print name) (signature)

Phone #: _____ Fax: _____ Date:_____

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