

Niagara Falls City School District  
Health Services

## Health History Form for New Employees

<b>Name:</b>	<b>DOB:</b>
<b>Position applying for</b>	<b>Gender:</b>
<b>Address:</b>	<b>Phone #:</b>
<b>Medical Provider:</b>	

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

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Have you:

Ever been a patient in a hospital or had out-patient surgery? Explain \_\_\_\_\_

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Had any injuries from an accident (i.e. MVA, falls, work related)? Explain \_\_\_\_\_

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Are you under a Health Care Providers care now? Explain \_\_\_\_\_

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Are you taking any Medications? Please List Here: \_\_\_\_\_

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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? \_\_\_\_\_

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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  
630 66<sup>th</sup> Street  
Niagara Falls, New York 14304  
Phone: 716-286-0787 or 716-286-0787

FAX: 716-286-0758