



American Steamship Company Liberty Steamship Company MEDICAL HISTORY

4702 Grand Av
Duluth, MN 55807
p: 218-249-6822

The purpose of this examination is to evaluate your health status in relationship to your job requirements.
It is not intended to take the place of a regular physical examination by your primary health care provider.

Name (Last, first, Initial)	Job Position	Date
Your Address	Home Phone	Soc. Sec. No.
	Date of Birth	Age
		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

PERSONAL MEDICAL HISTORY: Please check any of the following conditions you have had:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> 1. Allergy | <input type="checkbox"/> 15. Ankle swelling | <input type="checkbox"/> 29. Arthritis | <input type="checkbox"/> 43. Paralysis |
| <input type="checkbox"/> 2. Hay fever | <input type="checkbox"/> 16. Varicose veins | <input type="checkbox"/> 30. Rheumatism | <input type="checkbox"/> 44. Weakness of arm/leg |
| <input type="checkbox"/> 3. Anemia | <input type="checkbox"/> 17. Thrombophlebitis | <input type="checkbox"/> 31. Muscle disorder | <input type="checkbox"/> 45. Catches in the back |
| <input type="checkbox"/> 4. Blood disorder | <input type="checkbox"/> 18. Asthma | <input type="checkbox"/> 32. Broken bones | <input type="checkbox"/> 46. Disk trouble |
| <input type="checkbox"/> 5. Bruise easily | <input type="checkbox"/> 19. Emphysema | <input type="checkbox"/> 33. Back strain/pain | <input type="checkbox"/> 47. Dislocation |
| <input type="checkbox"/> 6. Heart murmur | <input type="checkbox"/> 20. Chronic bronchitis | <input type="checkbox"/> 34. Liver disease | <input type="checkbox"/> 48. Leg cramps |
| <input type="checkbox"/> 7. Rheumatic fever | <input type="checkbox"/> 21. Trouble breathing | <input type="checkbox"/> 35. Hernia | <input type="checkbox"/> 49. Foot trouble |
| <input type="checkbox"/> 8. High blood pressure | <input type="checkbox"/> 22. Shortness of breath | <input type="checkbox"/> 36. Blood in stools | <input type="checkbox"/> 50. Knee trouble |
| <input type="checkbox"/> 9. Heart attack | <input type="checkbox"/> 23. Tuberculosis | <input type="checkbox"/> 37. Kidney trouble | <input type="checkbox"/> 51. Shoulder trouble |
| <input type="checkbox"/> 10. Heart trouble | <input type="checkbox"/> 24. Ulcer disease | <input type="checkbox"/> 38. Convulsions | <input type="checkbox"/> 52. Elbow trouble |
| <input type="checkbox"/> 11. Leg pains when walking | <input type="checkbox"/> 25. Hepatitis/jaundice | <input type="checkbox"/> 39. Epilepsy | <input type="checkbox"/> 53. Hand trouble |
| <input type="checkbox"/> 12. Fainting/dizzy spells | <input type="checkbox"/> 26. Diabetes | <input type="checkbox"/> 40. Nervous disorder | <input type="checkbox"/> 54. Tendonitis |
| <input type="checkbox"/> 13. Frequent headaches | <input type="checkbox"/> 27. Thyroid problem | <input type="checkbox"/> 41. Nervous breakdown | <input type="checkbox"/> 55. Carpal tunnel syndrome |
| <input type="checkbox"/> 14. Skin rash | <input type="checkbox"/> 28. Tumor or cancer | <input type="checkbox"/> 42. Stroke | |

Please explain ALL items checked:

Yes	No	Have you ever been told that you had or have a chronic or serious illness?
Yes	No	Have you been advised to have a surgical operation or medical treatment that has not been done?
Yes	No	Have you missed more than 5 days from work in the past 12 months for illness or injury?
Yes	No	Are you now under a doctor's care for any condition? If yes, Explain:
Yes	No	Do you have any condition that may require a special work assignment or accommodation? If Yes, Specify:
Yes	No	Do you have any surgical scars? If Yes, Where:
Yes	No	Have you ever received Workers' Compensation and/or disability benefits for any illness or injury? If yes, give dates, company names, and explain:
Yes	No	Do you drink alcohol? Circle number of alcoholic beverages weekly: Less than 1 1-3 3-6 Over 6
Yes	No	Have you ever been evaluated or treated for chemical dependency?
Yes	No	Have you ever smoked cigarettes? How many years did you smoke? How many packs per day? Do you want to quit? If you no longer smoke, what year did you quit?
Yes	No	Have you been exposed to second hand smoke?
Yes	No	Do you have any allergies to medicines, chemicals, metals, animals, etc.? If yes, please list:
Yes	No	Are you taking any medications (including narcotics)? If yes, please List:

List previous job titles and all occupational exposures you have had.

I certify that the above answers are true and complete to the best of my knowledge and that misrepresentation or omission of facts may be cause for dismissal.

Employee Signature

DIP URINE	Albumin	Sugar	Spec. Gravity
	Time:	Signature:	