



1321 Unity Place, Suite
Lafayette, IN 47905
PH: 765.446.2450
FX: 765.446.1083

A FRANCISCAN ST. ELIZABETH HEALTH AND UNITY HEALTHCARE PARTNER

Date: _____

Sex: ____ Female ____ Male

Name (last) _____ (first) _____ (middle initial) _____

Address (street) _____

City _____ State _____ Zip code _____

Home Phone _____ - _____ - _____
(Area Code)

Date of Birth _____ - _____ - _____
(month) (day) (year)

Social Security # _____ - _____ - _____

In Case of Emergency Notify:

Name _____ Relationship _____

Address _____ Phone _____

Name _____

INDUSTRIAL HISTORY

Have you ever worked:

If yes, how many years?

- 1. as a miner (ie. coal, iron, etc) _____ Yes _____ No _____
- 2. in a foundry _____ Yes _____ No _____
- 3. as a sandblaster _____ Yes _____ No _____
- 4. as a chipper _____ Yes _____ No _____
- 5. as a grinder _____ Yes _____ No _____
- 6. as a welder _____ Yes _____ No _____
- 7. with asbestos/silicone _____ Yes _____ No _____
- 8. with poisonous materials _____ Yes _____ No _____
- 9. with radioactive substances _____ Yes _____ No _____
- 10. at a job requiring repetitive motion _____ Yes _____ No _____

Have you ever been sensitive to sunlight, chemicals, dusts, or other materials? Yes _____ No _____

Have you ever required special job assignment for health reasons? Yes _____ No _____
If "yes", please explain _____

List any hobbies/activities you are involved in (ie. models, carpentry, piano, etc)

MILITARY HISTORY

Have you ever been in the Uniformed Services? _____ Yes _____ No If "yes", which branch? _____

Years of Service? _____ Military job? _____

Assignment Locations? _____

FAMILY HISTORY

Living or Dead	Living/Quality of Health	Age at Death	Cause of Death
Father			
Mother			
Brothers			
Sisters			

Is there any family history of:

- Asthma _____ Yes _____ No Relationship _____
- Bleeding disorders _____ Yes _____ No Relationship _____
- Cancer _____ Yes _____ No Relationship _____
- Diabetes _____ Yes _____ No Relationship _____
- Heart disease _____ Yes _____ No Relationship _____
- High blood pressure _____ Yes _____ No Relationship _____
- Stroke _____ Yes _____ No Relationship _____
- Mental disorders _____ Yes _____ No Relationship _____

Name _____

Have you ever collected Workers Compensation? Yes No If "yes", please give details _____

Do you have any physical limitations or disabilities? Yes No If "yes", please give details _____

Are you presently taking any medications? Yes No If "yes", please give details _____

Are you able to lift at least 50 pounds? Yes No

Are you able to bend, stop, twist, kneel repetitively? Yes No

Are you able to lift objects and extend in front of
the body at waist and shoulder height? Yes No

Are you able to stand continuously from
7 ½ to 12 hours on concrete? Yes No

Are you able to climb ladders, platforms, etc. Yes No

Are you able to reach overhead repetitively? Yes No

I CERTIFY THAT I HAVE ANSWERED THE PRECEDING QUESTIONS TRUTHFULLY TO THE BEST OF MY ABILITY.

DATE _____ SIGNATURE _____

DATE _____ EXAMINER/PHYSICIAN SIGNATURE _____