

Power Equipment Maintenance, Inc.

Proven Performance / Quality Driven
PRE-EMPLOYMENT QUESTIONNAIRE
 EQUAL OPPORTUNITY EMPLOYER

Name (Last, First Middle)				Social Security Number		
Age	Sex	Birth date	Family physician	Physician's Address		
Please answer the following questions to the best of your knowledge.					YES	NO
1.	Have you been under the care of a doctor or clinic for the last six (6) months?					
2.	Have you ever had any operations, serious illness, or injuries?					
3.	Have you ever been hospitalized?					
4.	Have you a chronic or recurring ear infection?					
5.	Have you any trouble hearing or have any ringing in your ears?					
6.	Do you wear a hearing aid?					
7.	Do you have any eye problem that is not corrected by glasses or contact lenses?					
8.	Do you have frequent headaches?					
9.	Do you have glaucoma?					
10.	Have you ever had a tetanus toxoid injection?					
11.	Have you had a chronic cough, shortness of breath, or ever coughed blood?					
12.	Have you had asthma, hay fever, tuberculosis, or chronic bronchitis?					
13.	Have you had heart trouble, high blood pressure, or rheumatic fever?					
14.	Have you ever had chest pain or an irregular heart beat?					
15.	Have you had stomach or intestinal trouble, sever abdominal pain or ulcers?					
16.	Have you ever had liver problems, colitis, hemorrhoids, or rectal bleeding?					
17.	Have you ever been treated for kidney or bladder trouble or had kidney stones?					
18.	Have you ever had anemia, diseases of the blood, phlebitis, varicose veins, or swelling of the ankles?					
19.	Have you ever been told you had diabetes?					
20.	Have you ever had any seizures, disorders of the nervous system, or epilepsy?					
21.	Have you ever fainted or had paralysis or dizzy spells?					
22.	Have you lost consciousness in the last five (5) years?					
23.	Have you ever been clinically diagnosed for nervous exhaustion, depression, or mental breakdown?					
24.	Have you ever seriously considered suicide?					
25.	Have you been rejected for employment, military service, or life insurance for health reasons?					
26.	Do you have joint pain or arthritis?					
27.	Have you ever had any problems with your back, neck, knees, arms, shoulders, or joints?					
28.	Have you any condition that will require surgery in the future?					
29.	Are you now taking pills, injections, or medicines for any reason?					
30.	Do you have allergies (medicines, food, other)?					
31.	Do you have any recurring skin conditions (Dermatitis) or rash?					
32.	Have you any health problems not previously mentioned?					
33.	Have you ever been clinically diagnosed for drug use?					
34.	Have you ever had an on-the-job injury that resulted in a workman's compensation claim?					
35.	Have you ever been occupationally exposed to asbestos, silica, or other dusts?					
36.	Do you presently smoke?	Yes	No	How much?	What?	
	Have you ever smoked?	Yes	No	How much?	What?	
37.	Do you use alcohol beverages? Yes No					
38.	How may cups of coffee do you consume per day?					
Explain any "YES" answers to questions 1 through 35.						

I understand that this information will be kept confidential and it shall only be used to determine my physical qualifications for proper job placement. I agree to have a physical examination and am aware that false statements may be sufficient cause to disqualify me for employment, or, if employed, realize that any evidence of falsification of information will be considered adequate cause for discharge.

 Signature

 Date