

**FHM INSURANCE COMPANY  
MEDICAL HISTORY QUESTIONNAIRE**

(For Applicants Who Have Received Conditional Job Offers. The statement as found on this page must be signed by the applicant before completing the following medical questionnaire).

I herewith affirm that the employer has made me an offer of employment, conditioned on the satisfactory completion of this questionnaire and, if necessary, within the sole discretion of the employer, a medical examination. The purpose of this inquiry is to determine whether I currently have the physical or mental qualifications necessary to perform the essential functions of the job that has been offered, whether and what accommodations may be necessary, and whether I can perform the job without posing a direct threat to the health or safety of myself or others and for the purposes and reasons as stated on the attached questionnaire.

This information will be kept confidential in a separate medical file, apart from my personnel file. I herewith affirm that the questions as found in the attached medical questionnaire have not been asked of me by anyone with the employer until after I have signed this statement and been offered a job.

NAME \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_ WITNESS \_\_\_\_\_

SWORN TO AND SUBSCRIBED TO before me on this day \_\_\_\_\_ of \_\_\_\_\_ 20 \_\_\_\_\_

(SEAL) NOTARY PUBLIC \_\_\_\_\_

MY COMMISSION EXPIRES: \_\_\_\_\_

1. Have you ever had or been treated for any of the following conditions or diseases?

- | Yes                      | No                       |  | Yes                      | No                       |  |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy   | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes   | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac disease (heart trouble)  | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins   |
| <input type="checkbox"/> | <input type="checkbox"/> | Amputation of foot, leg, arm or hand   | <input type="checkbox"/> | <input type="checkbox"/> | Leg ulcer  |
| <input type="checkbox"/> | <input type="checkbox"/> | Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally         | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Residual disability from poliomyelitis (polio)   | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral palsy   | <input type="checkbox"/> | <input type="checkbox"/> | Allergies  |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple sclerosis   | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever or asthma  |
| <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's disease  | <input type="checkbox"/> | <input type="checkbox"/> | Skin trouble   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia   | <input type="checkbox"/> | <input type="checkbox"/> | Reaction to serum or drug  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic osteomyelitis (bone infraction)  | <input type="checkbox"/> | <input type="checkbox"/> | Kidney or bladder trouble  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperinsulinism (low blood sugar)  | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers   |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular dystrophy   | <input type="checkbox"/> | <input type="checkbox"/> | Head injury  |
| <input type="checkbox"/> | <input type="checkbox"/> | Thrombophlebitis (inflammation of a vein with a blood clot formed in the vein)                                     | <input type="checkbox"/> | <input type="checkbox"/> | Cancer   |
| <input type="checkbox"/> | <input type="checkbox"/> | Herniated intervertebral disc (slipped disc)   | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or fainting spells                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical removal of intervertebral disc or fusion  | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis or rheumatism  |
| <input type="checkbox"/> | <input type="checkbox"/> | Total deafness   | <input type="checkbox"/> | <input type="checkbox"/> | Knee injury  |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental retardation   | <input type="checkbox"/> | <input type="checkbox"/> | Backache   |
| <input type="checkbox"/> | <input type="checkbox"/> | Menisectomy (removal of cartilage from knee)   | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder injury  |
| <input type="checkbox"/> | <input type="checkbox"/> | Patellectomy (knee cap removal or replacement)   | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism   |
| <input type="checkbox"/> | <input type="checkbox"/> | Ruptured cruciate ligament (of the knee)   | <input type="checkbox"/> | <input type="checkbox"/> | Drug addiction   |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical or spontaneous fusion of a major weight bearing joint   | <input type="checkbox"/> | <input type="checkbox"/> | Severe headaches   |
| <input type="checkbox"/> | <input type="checkbox"/> | One or more back injuries or diseased process of the back resulting in disability over a total of 120 or more days | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough  |
| <input type="checkbox"/> | <input type="checkbox"/> | Prior industrial accidents with this company or affiliated company   | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath  |
| <input type="checkbox"/> | <input type="checkbox"/> | Any permanent physical condition which constitutes a 20 percent impairment of a member or of the body as a whole   | <input type="checkbox"/> | <input type="checkbox"/> | Nervous breakdown  |
|                          |                          |  | <input type="checkbox"/> | <input type="checkbox"/> | Mental illness, psychiatric treatment or professional counseling |

2. Please list any condition or diseases for which you have been treated in the past 3 years. If no treatment has been provided, state "none".

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3. Have you ever been hospitalized? If so, for what condition? If you have not been hospitalized, state "none".

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4. Have you ever been treated by a psychiatrist or psychologist? If so, for what condition? If no such treatment has been received, state "none".

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5. Have you ever been treated for any mental condition? If no such treatment has been received, state "none".

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6. Is there any health-related reason you may not be able to perform the job for which you are applying? If yes, please explain. If no reason, state "none".

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7. Have you had a major illness in the last 5 years? If none, state "none".

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8. How many days were you absent from work because of illness last year? If none, state "none".

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9. Do you have any physical defects which preclude you from performing certain kinds of work? If yes, describe such defects and specific work limitations. If none, state "none".

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10. Do you have any disabilities or impairments which may affect your performance in the position for which you are applying? If none, state "none".

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11. Are you taking any prescription medications? If yes, state the medication and the reason for taking it. If no medications are being taken, state "none".

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12. Have you ever been treated for drug addiction or alcoholism? If yes, identify the medical care provider and dates of treatment. If no treatment has been provided, state "none".

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13. Have you ever filed for Workers' Compensation insurance? If yes, please describe in detail. If no, state "none".

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Witness \_\_\_\_\_ Applicant for Employment \_\_\_\_\_

Witness \_\_\_\_\_