

UNM-SOM MEDICAL HISTORY FOR HOUSE OFFICERS

| | |
|--|---------------------------|
| 1. LAST NAME, FIRST NAME, MIDDLE INITIAL | 2. DATE OF BIRTH |
| 3. ALBUQUERQUE ADDRESS | 4. SOCIAL SECURITY NUMBER |

5. GENERAL STATEMENT OF CURRENT HEALTH (INCLUDE DETAILS FROM #7 BELOW):

6. Do You

| YES | NO | |
|-----|----|--|
| | | WEAR CORRECTIVE LENSES? |
| | | HAVE VISION IN BOTH EYES? |
| | | HAVE SIGNIFICANT HEARING IMPAIRMENT? |
| | | HAVE JOINT DISEASE? |
| | | USE ASSISTIVE DEVICES FOR AMBULATION? |
| | | TAKE MEDICATION CHRONICALLY? (LIST IN #5 ABOVE, IF NECESSARY.) |

7. HAVE YOU EVER HAD (OR DO YOU HAVE)

| YES | NO | | YES | NO | |
|-----|----|-------------------------------|-----|----|-----------------------------|
| | | REUMATIC FEVER? | | | SERIOUS INSOMNIA? |
| | | SEASONAL ALLERGIES OR ASTHMA? | | | DEPRESSION? |
| | | A BLEEDING DISORDER? | | | SERIOUS CNS INJURY? |
| | | TUBERCULOSIS? | | | SEVERE HEADACHE? |
| | | HYPERTENSION? | | | ADVERSE REACTION TO DRUGS? |
| | | PEPTIC ULCER DISEASE? | | | AMPUTATION? |
| | | IRRITABLE BOWEL SYNDROME? | | | PROBLEM WITH ALCOHOL ABUSE? |
| | | HEPATITIS B? | | | PROBLEM WITH DRUG ABUSE? |
| | | HEPATITIS A OR OTHER? | | | DIABETES? |
| | | SEXUALLY TRANSMITTED DISEASE? | | | SEIZURE DISORDER? |
| | | ANY MALIGNANCY? | | | CHICKEN POX? |

8. HAVE YOU EVER (IF YES, EXPLAIN IN SPACE TO RIGHT)

| YES | NO | | |
|-----|----|--|--|
| | | BEEN DENIED LIFE INSURANCE? | |
| | | BEEN UNABLE TO HOLD A JOB FOR HEALTH REASONS? | |
| | | BEEN TERMINATED FROM A JOB FOR PROBLEMS OF ALCOHOL OR SUBSTANCE ABUSE? | |
| | | MADE A SUICIDE ATTEMPT? | |
| | | HAD A SERIOUS ILLNESS OR INJURY OTHERWISE NOTED ON THIS FORM? | |
| | | RECEIVED OR IS THERE ANY PENDING FORM OF COMPENSATION, DISABILITY OR PENSION FOR EMPLOYMENT RELATED INJURY OR ILLNESS? | |

9. I CERTIFY THAT I HAVE REVIEWED ALL THE INFORMATION ON THIS FORM AND HAVE ANSWERED ALL THE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.

DATE

SIGNATURE

10. HAVE REVIEWED THIS HISTORY IN CONJUNCTION WITH PERFORMING A PRE-EMPLOYMENT PHYSICAL EXAMINATION FOR THIS PHYSICIAN AND HAVE SATISFIED MYSELF AS TO ITS COMPLETENESS.

DATE

SIGNATURE OF EXAMINING PHYSICIAN