ENRICHED HOME CARE AGENCY INC. **EMPLOYEE HEALTH ASSESSMENT**

Annual Assessment **Other:**

Name:	Marital Status: M S W D	Sex: M F
Address	SS #:	Title:

Emergency Contact: **Relationship:**

Emergency Adress: **Telephone No.:**

INDICATE ILLNESS EXPERIENCED BY YOU OR FAMILY

CONDITION	YES	NO	CONDITION	YES	NO
DIABETES			MIGRAINE HEADACHES		
KIDNEY DISEASE			FAINTING OR DIZZINESS		
HEART DISEASE			WEIGHT GAIN/LOSS 15+ LBS.OR MORE		
HIGH BLOOD PRESSURE			CHANGE IN ENERGY LEVEL		
ARTHRITIS			FREQUENT COUGH		
TUBERCULOSIS			BLOOD IN SPUTUM		
MENTAL ILLNESS			SHORTNESS OF BREATH		
EPILEPSY/CONVULSIONS			CHEST PAIN/PRESSURE IN CHEST		
CANCER			SWELLING IN LEGS AND FEET		
TB SCREEN YES NO			PAIN IN CALF WHEN WALKING		
Have you experienced the following symptoms			CHANGE IN BOWEL HABITS		
Chest Pain			BACK PAIN		
Lingering Cough			HIGH BLOOD PRESSURE		
Loss of Energy			PAIN WHEN URINATING/BLOOD IN URINE		
Weight Loss +15 lbs in past year			INFECTIOUS DISEASE		
Blood in Sputum			INCREASED THIRST		
Increased Sweating at Night			PERSISTANT SORES OR LUMPS		

Do you smoke? Yes No if yes, how much?

Do you drink alcoholic beverages? Yes No if yes, how much?

Do you take depressant, stimulant, narcotic drugs that alter your behavior? Yes No

Do you take prescription medications? Yes No if yes, which medications?

Name of your Physician:

Address: Telephone No:

I have read the above and declare that I have had no injury, illness or ailment other than as specifically identified. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

Signature: Date: