Applicant Name _____ Last 4 Digits of SSN _____

☐ **COVID19 Vaccine Requirement**

For OHR Use Only

Department_____ Division:_____Position_____

Clearance Date_____ ☐ **Check here for temporary/seasonal positions.**

OHR Specialist_____ Hiring Department Contact_____

OFFICE OF HUMAN RESOURCES
OCCUPATIONAL MEDICAL SERVICES
27 Courthouse Square, Suite 184
Rockville, Maryland 20850
(240) 777-5118 Fax (240) 777-5132

MONTGOMERY COUNTY, MARYLAND
REPORT OF APPLICANT'S MEDICAL HISTORY

You have received an offer of employment conditioned on the result of this medical evaluation. The information submitted is used to determine your ability to perform the essential functions of the job for which you applied and could be used for evaluation in future workers' compensation claims. If necessary, you may request a reasonable accommodation consistent with provisions of the Americans with Disabilities Act and Montgomery County Personnel Regulations (MCPR), Section 8. See http://www.montgomerycountymd.gov/HR/LaborRelations/PersonnelRegulation.html. The aforementioned law and County regulation in part require that an applicant be able to perform the essential job functions, with or without a reasonable accommodation. The County will take appropriate action to comply with any such request. This form is to be completed and sent directly to Occupational Medical Services (OMS). Your employment application will not be further processed until OMS receives and evaluates this **completed** report. The information provided will be maintained in confidential medical files in accordance with MCPR, Section 4, and will be kept in the medical section of the Office of Human Resources (OHR). The information will be reviewed only by Occupational Medical Services or other authorized persons. Please print and use ink to complete this form. **The medical evaluation cannot proceed unless all items below are answered fully.**

Note: This form is both a County personnel record and a record of the County's retirement system. Any information presented on this medical history form may also be used to evaluate an individual's future eligibility for disability or disability retirement benefits. This form is not used to determine eligibility for insurance benefits, nor will this form be provided to health insurers without your written consent.

LAST NAME	FIRST NAME	MIDDLE NAME	POSITION APPLIED FOR	
HOME ADDRESS (STREET, CITY, STATE, ZIP CODE)			SOCIAL SECURITY NUMBER	
( )	( )			
HOME TELEPHONE	OFFICE TELEPHONE	DATE OF BIRTH	AGE	SEX
EMERGENCY CONTACT (NAME, ADDRESS, PHONE)				
HEALTH CARE PROVIDER (NAME, ADDRESS, PHONE)				
DATE OF LAST PHYSICAL			DATE OF LAST CHEST X-RAY OR TB TEST	

Statement of Personal Health (in your own words):

_____

Have you been medically evaluated by Montgomery County in the past as a job applicant? ☐ Yes ☐ No

If YES, state date and position:

_____

_____

Do you currently have any physical or mental conditions or are you currently disabled in any way that may limit your ability to perform the job for which you have applied? ☐ Yes ☐ No

If YES, explain:

_____

_____

Do you wear a hearing aid or use an assistive device such as (i.e. wheelchair, cane, crutches, walker, or artificial limb)? ☐ Yes ☐ No

If Yes, please specify:

_____

_____

Do you have any disability requiring a reasonable accommodation in order for you to perform this job? ☐ Yes ☐ No

If YES, explain:

_____

_____

_____

Have you been refused employment or been terminated from a job due to:

1. sensitivity to chemicals, dust, sunlight, etc…… ☐ Yes ☐ No
2. inability to perform certain motions……... ☐ Yes ☐ No
3. inability to assume certain positions…….. ☐ Yes ☐ No
4. any other medical, psychological, or physical reason? …….. ☐ Yes ☐ No

If YES to any above, give date(s) and explain:

_____

_____

_____

Have you, within the past 3 years, had to change jobs because of a diagnosed injury or illness (physical or psychological)? ☐ Yes ☐ No

If YES, give date(s) and explain:

_____

_____

Have you been a patient in a hospital or rehabilitation center within the past 3 years? ☐ Yes ☐ No

If YES, give date(s) and explain:

Have you, within the past 3 years, been advised to have surgery that you declined to have? ☐ Yes ☐ No

If YES, give date(s) and explain:

Applicant Name _____ Last 4 Digits of SSN _____

Within the past 3 years, have you had any of the following? (complete all 3 columns)

	Y	N		Y	N		Y	N
1. Abnormal Chest X-ray			24. Stroke			47. Shoulder/arm Condition		
2. Abnormal EKG			25. Intestinal Condition			48. Speech Impairment		
3. Allergies			26. Kidney/UTI condition			49. Post Traumatic Stress		
4. Blood in Urine			27. Liver Disease			50. Paralysis		
5. Bone Disease			28. Rheumatic Fever			51. Back or Neck Pain		
6. Chronic Sleep Disorder			29. Heart Palpitations			52. Rash or Skin Condition		
7. Chronic Cough			30. Pancreatitis			53. Loss of consciousness		
8. Chronic Diarrhea			31. Phlebitis/Blood Clot			54. Anemia		
9. Collapsed Lung			32. Pneumonia			55. Cancer or Tumor		
10. Detached retina			33. Poor Night Vision			56. Clinical Depression		
11. Diabetes			34. Prostate Cancer			57. Hernia		
12. Tuberculosis			35. Slipped/Ruptured Disc			58. Head Injury		
13. Stomach Ulcer			36. Loss of Limb/Finger/Toe			59. Alcoholism		
14. Varicose Veins			37. Significant Tremors/ Shaking			60. Epilepsy/Seizure		
15. Wheezing/Asthma			38. Sciatica or Neuritis			61. Learning Disability		
16. Yellow Jaundice			39. Arthritis or Gout			62. Drug Addiction		
17. Gall Bladder Condition			40. Dizziness/Fainting			63. Chronic Fatigue		
18. Heart Attack			41. Fractured Bone			64. Memory Impairment		
19. Heart Murmur			42. Severe Headaches			65. Swollen/Painful Joint		
20. Thyroid Condition			43. Psychological/Mental Condition			66. Bursitis		
21. High Blood Pressure			44. Hearing Impairment			67. Bleeding Disorder		
22. High Cholesterol			45. Cataracts			68. Other		
23. Hypoglycemia			46. Knee/leg/ankle/foot Condition					

Explain all YES answers by number. Be sure to include dates and types of treatments, where applicable.

Have you experienced the following within the past 3 years?

	Y	N		Y	N
1. Wheezing/Asthma	☐	☐	10. Leg Pain	☐	☐
2. Hemorrhoids	☐	☐	11. Fear of Heights	☐	☐
3. Chest Pain/Pressure	☐	☐	12. Diminished Night Vision	☐	☐
4. Heart Palpitations	☐	☐	13. Frequent Dizziness/Fainting	☐	☐
5. Double Vision	☐	☐	14. Significant Tremors/ Shaking	☐	☐
6. Shortness of Breath	☐	☐	15. Fear of Close Spaces	☐	☐
7. Frequent Indigestion	☐	☐	16. Frequent Infections	☐	☐
8. Poor Urine Control	☐	☐	17. Significant Back or Neck Pain	☐	☐
9. Significant Intestinal Discomfort	☐	☐	18. Recent Substantial Weight Change	☐	☐

Explain all YES answers by number. Be sure to include dates and types of treatments, where applicable.

Do you have allergies to any of the following? Check all that apply.

☐ Food	☐ Bee stings
☐ Soaps or detergents	☐ Pollen
☐ Metals, chromium	☐ Insect scales
☐ Nickel	☐ Animal dander
☐ Rubber	☐ House Dust
☐ Epoxy resins	☐ Industrial chemicals
☐ Plants (poison ivy)	☐ Others:

Check the box below if you have been immunized against:

☐ Hepatitis B	☐ Tetanus
☐ Rubella (German measles)	☐ Mumps
☐ Varicella (Chicken Pox)	☐ Rubeola (Measles)
☐ Polio	☐ Rabies
☐ Hepatitis A	☐ Other

Are you pregnant or is there a possibility you are? ☐Yes ☐No

Do you wear: ☐ glasses ☐*contact lenses ☐ artificial eye

*If wearer of contact lenses, indicate whether: ☐ Soft ☐ Hard ☐ Gas Permeable

Have you any medical or other restriction pertaining to driving a motor vehicle? ☐Yes ☐No

If YES, explain:

_____

_____

_____

Are you currently taking prescription medications? ☐Yes ☐No

If Yes, please list:

_____

_____

Are you currently taking any over the counter medications (decongestants, antihistamines, cough medicines) or supplements (i.e. St. Johns Wort, Echinacea) that may cause drowsiness? ☐Yes ☐No

If Yes, please list:

_____

Are you currently on any special diets recommended by a health care provider? ☐Yes ☐No

If Yes, explain:

_____

_____

Have you ever smoked or used tobacco of any type? ..... ☐Yes ☐No

Do you currently smoke?..... ☐Yes ☐No

If Yes, to either question, how long and how much? _____

Do you drink alcoholic beverages? ☐Yes ☐No

If Yes, Check: ☐ daily ☐weekly Daily or weekly amount:_____

Within the past 3 years, have you been advised by a health care provider to reduce your consumption of alcohol because of a health condition resulting from or made worse by drinking alcohol? **If Yes,** explain: ☐Yes ☐No

_____

_____

_____

To the best of your knowledge, have you had an exposure to any of the following either in your work or while engaged in a hobby?

1.	Mercury (scientific instruments, chlorine plants, dental offices)……..	☐Yes ☐No
2.	Arsenic (insecticides) ……	☐Yes ☐No
3.	Acrylamide (construction, grouting)…….....	☐Yes ☐No
4.	Hexane (solvents, rubber cements, inks)……	☐Yes ☐No
5.	Trichloroethylene (trichlor ”tri”, degreasing)…….	☐Yes ☐No
6.	Perchloroethylene (perchlor, perc, dry-cleaning industry)…….	☐Yes ☐No
7.	Pesticides……	☐Yes ☐No
8.	Methyl butyl keytone (MEK, inks) ……	☐Yes ☐No
9.	Carbon Disulfide (rayon/rubber industry, labs) ……	☐Yes ☐No
10.	Lead (jewelry, foundries, battery industries, ammunition) ……	☐Yes ☐No
11.	Toluene (solvents, lacquers, inks) …….	☐Yes ☐No
12.	Methylene Chloride…….……	☐Yes ☐No
13.	Carbon Monoxide (by-products of combustion) ……..	☐Yes ☐No
14.	Fumes or hazardous Gases…….……	☐Yes ☐No
15.	Asbestos…….…….……	☐Yes ☐No
16.	Industrial dust or flames…….…….……	☐Yes ☐No
17.	Radioactive material, lasers, x-rays, radar …….……	☐Yes ☐No
18.	Frequent or prolonged exposure to extreme temperatures …….	☐Yes ☐No
19.	Loud industrial noise…….…….……	☐Yes ☐No
20.	Firearms/guns…….…….……	☐Yes ☐No
21.	Frequent or prolonged use of a chain saw…….…….	☐Yes ☐No
22.	Frequent or prolonged use of lawn equipment or chippers…….	☐Yes ☐No
23.	Frequent or prolonged exposure to motorcycle noise…….	☐Yes ☐No
24.	Frequent or prolonged use of industrial equipment that causes vibrations…… (e.g. jackhammers).	☐Yes ☐No

If Yes, describe by number the exposure and estimate dates and duration of exposure:

_____

_____

_____

Do you have any hobbies, such as the ones below, which could expose you to glues, solvents, or chemicals?

1. Painting……. ☐Yes ☐No
2. Furniture Refinishing……..... ☐Yes ☐No
3. Lead Glass Making…….. ☐Yes ☐No
4. Auto Body Work……. ☐Yes ☐No
5. Jewelry Making……... ☐Yes ☐No
6. Pottery Making or Ceramics…… ☐Yes ☐No
7. Other (please explain): _____

If Yes, estimate time involved in the activity:

_____

_____

_____

To the best of your knowledge, have you ever had an illness or symptoms resulting from exposure to a chemical or hazardous materials not listed above? ☐Yes ☐No

If Yes, give date(s) and explain:

_____

_____

_____

In the past 3 years, have you regularly worn any of the following **protective equipment** in your previous work or while engaged in your hobby?

1. Ear plugs/muffs…….. ☐Yes ☐No
2. Goggles/face mask……. ☐Yes ☐No
3. Dust mask…….. ☐Yes ☐No
4. Respirator…….. ☐Yes ☐No
5. Gloves…… ☐Yes ☐No
6. Apron or gown……..... ☐Yes ☐No
7. *Other ……... ☐Yes ☐No

*please explain:

_____

_____

_____

FIREFIGHTER/RESCUER POSITION ONLY ALCOHOL USE

Are you, or have you been in the past 3 years, a volunteer firefighter or cadet with Montgomery County MD? **If Yes**, explain: ☐Yes ☐No

_____

_____

_____

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. Further, I understand the following:

1. That any offer of employment is conditioned on the results of this medical evaluation.

2. Any intentionally false or misleading statement may result in the rejection of my application for employment or in my discharge from County employment. Such a false or misleading statement may also exclude me from coverage in the County medical disability retirement or disability benefit programs.

3. That I may be required to provide additional medical information and/or undergo further medical evaluation as a condition of employment.

4. Upon your written request, a copy of this form or any component of your medical record will be made available to you in accordance with MCPR Section 4.

Applicant's Signature_____Date_____

Parents Signature (if minor child) _____ Date _____

****

Physician/Nurse comments, summary, or elaboration of all pertinent data.

_____

_____

_____

_____

_____

_____

_____

_____

Montgomery County Physician/Nurse Signature

_____Date_____