

MT. WASHINGTON PEDIATRIC HOSPITAL, INC.
VOLUNTEER HEALTH ASSESSMENT

Identification Data: Fill in the following. Please print

_____	Date of Birth _____
Name _____	Sex: Male _____ Female _____
_____	_____
Social Security Number _____	Area Code, Phone Number _____
_____	_____
Address _____	Volunteer Job Title _____

City, State and ZIP code _____	

Health History: mark an "X" next to any of the following illnesses you now have or have ever had.

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Musculoskeletal problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Hives or rashes |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Kidney/bladder trouble |
| <input type="checkbox"/> Cancer/tumor | <input type="checkbox"/> Liver disease/hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Bowel/Stomach problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Rheumatism/arthritis |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Skin disorders |

Have you had any work-related injuries or illnesses? yes no. If yes, explain _____

Do you have any drug allergies? Explain _____ Other allergies? _____

Immunization/ infectious disease history: Place an "X" next to those infections/immunizations you have had.

Measles German measles Mumps Chicken pox Polio

Have you ever had a tuberculosis skin test? yes no. Was there a reaction requiring a chest X-ray? yes no.

Have you ever been turned down for life insurance, military service or employment because of health problems? yes no. If yes, explain _____

Current health status: Mark an "X" next to the following for any current problem.

Never smoked Smoking currently Stopped smoking years ago

Alcohol consumption daily weekly never

Drug use Cough

Eye/vision problems Shortness of breath

Hearing Problems Frequent headaches

Do you wear glasses? yes no; contact lens yes no.

List any medications that you are taking _____

I testify that the information which I have given is accurate and complete.

Signature

Date

The following statement must be signed by your health provider (physician or health service)

I have examined the above prospective volunteer and find him/her mentally and physically able/
unable to perform duties at Mt. Washington Pediatric Hospital.

Print name of examiner

Signature

Address of examiner

Date of assessment