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www.SBCounty.gov

SAN BERNARDINO COUNTY

Human Resources
Center for Employee Health and Wellness

POST-OFFER MEDICAL HISTORY QUESTIONNAIRE

IDENTIFICATION

Name	Other Names Used	Today's Date
Social Security Number *Last 6 digits*	Phone Number	Date of Birth
Mailing Address *Street, City, State, Zip Code*		
Personal Email Address	Work Email Address	
Job Title Applied For	Department	

CURRENT AND PRIOR EMPLOYMENT

Have you ever been or are you now employed by San Bernardino County? ☐ Yes ☐ No

If yes, what year were you hired? _____

MEDICAL INFORMATION

Are you currently taking any medication (prescription [including as needed] or non-prescription) that affect your balance, awareness, hearing, sight, ability to walk, stand, sit, bend, or reach? ☐ Yes ☐ No

If yes, please list the Name and/or Type of medication along with any specific work restrictions:

_____

_____

_____

_____

Print Name: _____

STATEMENT OF HEALTH CONDITION

1. Have you undergone any operations, surgeries, procedures, or hospitalizations that may limit your current ability to perform the essential physical or mental functions of the position for which you are being considered? ☐ Yes ☐ No

If yes, please provide the following information:

Date of procedure/hospitalization: _____

Specific work limitation(s): _____

2. As of this date or currently, has a physician or treating provider restricted you from performing any physical or mental activities that are necessary to perform the job for which you are being considered? ☐ Yes ☐ No

If yes, please complete the table below:

Date Restriction Issued	Name of Physician/Provider	Restriction

3. Did you request an accommodation (e.g. adaptive equipment, reader, additional time, quiet space, etc.) during the pre-employment or selection process (e.g. testing, interviewing, background, polygraph, physical agility test or other portions of the process)? ☐ Yes ☐ No

If yes, did you receive the requested accommodation? ☐ Yes ☐ No

4. Do you need a work-related accommodation for any mental or physical condition that may limit your current ability to perform the essential functions of the job for which you are being considered?

Including but not limited to: vision impairment, hearing impairment, allergies, skin conditions, dizziness, fainting, loss of consciousness, working in elevated locations, convulsions, seizures, epilepsy, breathing problems, diabetes, headaches, and psychological or emotional disorders. ☐ Yes ☐ No

If yes, please list the specific job functions that you believe you cannot perform without a work-related accommodation.

_____

_____

_____

Print Name: _____

5. Do you have any chronic pain, muscular, or skeletal problems that may limit your ability to perform the essential functions of the job for which you are being considered?

Including but not limited to: pain; weakness; tingling; numbness; limited motion; any limitations due to walking, standing, sitting, bending, lifting, and reaching. ☐ Yes ☐ No

If yes, please check or describe the body part(s) affected:

☐ Neck ☐ Shoulder ☐ Ankle ☐ Wrist ☐ Hand ☐ Back ☐ Hip ☐ Knee ☐ Elbow ☐ Foot

☐ Other

Please indicate any limitations created by your condition:

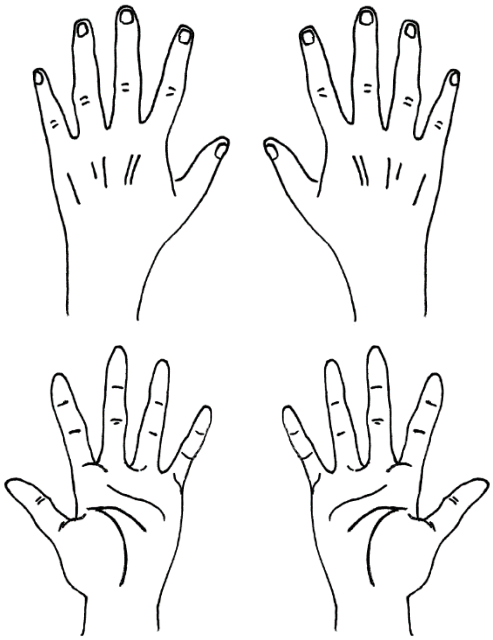
_____

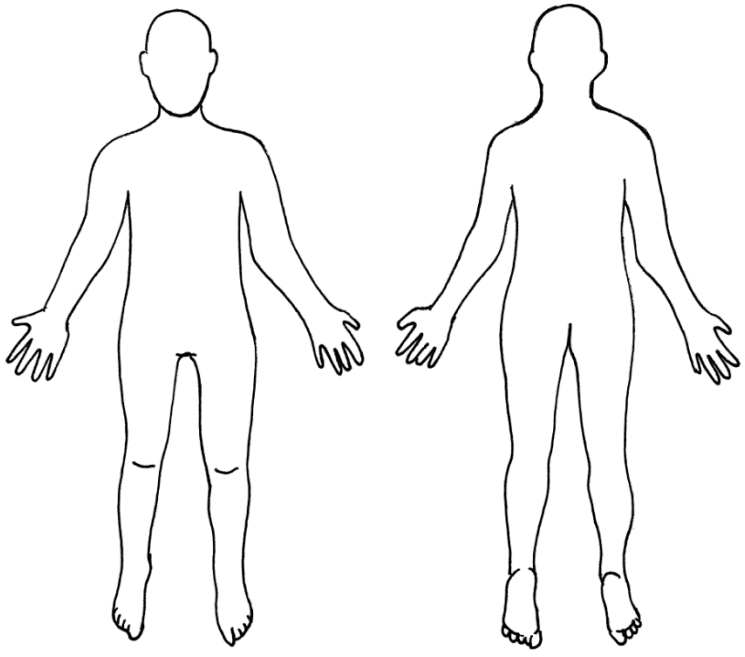
_____

_____

6. Please mark on the diagrams where you experience any pain, weakness, tingling, numbness, or other problems in response to question five.

Type	Symbol
Pain	X
Tingling or Numbness	T
Weakness	O





Print Name: _____

7. Based on what you know about the position for which you are being considered, can you perform the essential functions with or without reasonable accommodations? ☐ Yes ☐ No

If no, please describe your concerns.

_____

_____

_____

I certify that the information given by me is true, correct, and complete to the best of my knowledge and belief. I understand that any material misstatements or omissions of facts may lead to disciplinary action and/or loss of employment with San Bernardino County, either before or after such employment has commenced.

Signature: _____ Date: _____

Print Name: _____

POTENTIALLY HAZARDOUS ENVIRONMENT

Answer the following question only if the job you applied for requires that you work in an environment where you are likely to come into contact with chemicals or substances (e.g., latex, radiation, lead, paints, glues, dust); or use protective gear or equipment.

Do you have an allergy and/or sensitivity (e.g., irritation to eyes or skin, difficulty breathing) to latex, chemicals, dust, asbestos, or other environmental substances that may limit your current ability to perform the essential duties/functions of the job for which you are being considered? ☐ Yes ☐ No

If yes, please indicate the chemicals or substances you are sensitive to and any specific work limitations:

_____

_____

_____

SAFETY APPLICANTS ONLY

Answer the following question only if you applied for a safety position (e.g., Peace Officer, Firefighter, Probation Officer, etc.)

Do you now or have you ever been diagnosed with the following conditions?

☐Diabetes/high or low blood sugar

☐Epilepsy, convulsions, or seizures

☐Color blindness/deficiency

☐Asthma or emphysema

☐Heart Disease, murmur, palpitations, or irregular heartbeat

☐High or low blood pressure

☐Hearing difficulty/hearing aid

☐Other medical condition, injury, or surgery

If you marked any of the above, please enter the year of diagnosis and any additional comments or clarification:

_____

_____

_____

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Signature: _____ Date: _____