

ADULT EMPLOYEE 18 YEARS OF AGE AND OLDER RULE 125
HEALTH HISTORY RECORD
Michigan Department of Social Services

STAFF MEMBER'S NAME (Last, First, M.I.)

MAILING ADDRESS (City, State, Zip Code)

TELEPHONE NUMBER

DATE OF BIRTH

SEX

PERSONAL PHYSICIAN'S NAME

ADDRESS

Number & Street

City

State

Zip Code

TELEPHONE NUMBER

May we contact your physician regarding
physical condition? () Yes () No

CURRENT HEALTH ISSUES AND HISTORY

List any allergies you have:

Do you have any health problems including current infectious disease () Yes () No If yes, explain.

List physical limitations if any:

List any medications you take regularly:

Name

Frequency

Dosage

I certify that this information is true to the best of my knowledge.

SIGNATURE

DATE