



Employee Health Risk Assessment Questionnaire

Employee Name _____

Position Applied for _____

Please Answer the Questions below and return this Questionnaire to Elohim Homecare. (If “Yes” please give explanation on comment line below).

		Yes	No	Unknown
1	Have you ever had any illness that may have been caused by or made worse by your work?			
2	Do you consider yourself as having disability? If yes, do you need any adjustments or modifications to do the job you have applied for?			
3	Have you ever had Active, Untreated Tuberculosis?			
4	Any disease associated with severe immunologic deficiency?			
5	Have you ever had HIV or any other STD?			
6	Have you ever had Epilepsy, seizures, sudden unexplained dizziness or loss of consciousness			
7	Do you have difficulty bending, standing, lifting or any other movements			
8	Have you ever had any mental illness or psychological problems including depression, anxiety, schizophrenia etc.			
9	Have you ever had any drug or alcohol related problems			

Comments: _____

Do you currently have:

- | | |
|---|--|
| 1) Unexplained fever (Y) (N) | 6) Cough lasting more than 3 weeks(Non related to Viral upper infection or chronic lung disease) (Y) (N) |
| 2) Unexplained weight gain or weight loss? (Y) (N) | 7) Coughing up blood (Y) (N) |
| 3) Unexplained fatigue or malaise (More than 3 weeks) (Y) (N) | 8) Any exposure to tuberculosis or any other communicable diseases in the past year (Y) (N) |
| 4) Night Sweats (Y) (N) | |
| 5) Unexplained loss of appetite (Y) (N) | |

Comments: _____

I certify that I have read this document answered all the questions to the best of my Knowledge and Ability.

Employee’s Signature _____

Date _____