MS Form 10-500

GEORGIA
DEPARTMENT OF CORRECTIONS

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Health Information Checklist

This checklist contains questions regarding your medical history and health. The primary use of this information will be to alert the employer and applicant of conditions that could negatively impact the health of customers or co-workers. This information may be used to determine fitness to perform job duties. This information will be handled in a confidential manner. It is essential that you answer all questions truthfully and completely. False or incomplete information may result in disqualification or termination if hired.

Completed by Applicant/Employee

(Type or Print in Ink)

Section I

Date: _____

Employee Name: _____ Social Security Number _____-_____-_____

Last, First Middle

Employing Agency: _____ Date Employed: _____

Section II

Have you now, or ever had the following?	Yes	No
1. Loss of sight of both eyes. Loss of uncorrected (without glasses or contact lens) vision of more than 75% bilaterally (vision of 20/160 or J* or worse using both eyes).		
2. Diabetes		
3. Tuberculosis		
4. Epilepsy (convulsions, seizures or fits)		
5. Ankylosis (immobility) of major weight bearing joints (ankles, knee, hip)		
6. Any permanent condition which causes 20% (or more) impairment of a foot, leg, hand, arm, back, or the body as a whole		
7. Arthritis which is a hindrance to employment		
9. Amputated (loss of) foot, leg, arm, or hand		
10. Parkinson's disease (Paralysis Agitans)		
11. Cerebral palsy		
12. Multiple sclerosis		
13. Mental retardation (intelligence quotient within the lowest two percent of the general population)		

	Yes	No
14. Psychoneurotic disability following confinement for treatment in a recognized medical or mental hospital for a period in excess of six months.		
15. Hemophilia		
16. Sickle cell anemia		
17. Cardiovascular (heart or blood vessel) disease		
18. Total occupational loss of hearing (loss of over half of hearing in each ear)		
19. Compressed air sequelae (damage to lungs, ruptured ear drum, etc e to air concussion, blasting, explosion, etc.)		
20. Muscular dystrophy		
21 Hyperinsulinism (hypoglycemia)		
22. Residual disability from poliomyelitis (Disability due to polio)		
23. Ruptured intervertebral (back) disc		
23. Chronic osteomyelitis (bone infection)		
24. Hepatitis		

REMARKS:_____

_____

_____

_____ _____

Signature of Employee Date

(MS Form 10-52)

GEORGIA
DEPARTMENT OF CORRECTIONS

STATE OF GEORGIA Name_____ Soc. Sec. No. _____-_____-_____

MEDICAL AND PHYSICAL Job Title _____ Department _____

EXAMINATION PROGRAM

MEDICAL HISTORY REPORT Job Category (circle one) 1 2 3 4 5

The purpose of these questions is to gather information concerning your health and physical condition, both now and in the past. This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered. Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave it blank and request assistance.

I certify under penalty of perjury, that the information given by me is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia, may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this medical history form.

EMPLOYEES' SIGNATURE: _____ DATE: _____

Individual History – To Be Completed By Applicant/Employee (Use Ink)

A. MEDICAL CONDITIONS. Check every item. Do you have or have you ever had any of the following: (If "Yes," give date of most recent occurrence and explain on page 3.)

Health Condition	*Yes*	*Year*	*No*
HEAD, NOSE, MOUTH AND THROAT			
1. Persistent or severe headaches			
2. Frequent nose bleeds			
3. Frequent nasal congestion			
4. Persistent or severe sinus condition			
5. Bleeding gums			
6. Persistent or severe dental condition			
7. Hoarse when don't have cold			
8. Difficulty swallowing			
9. Persistent sore throat			
10. Loss of taste or smell			
11. Head injury			
12. Other head, nose, mouth or throat conditions:			
EARS AND HEARING			
13. Hearing difficulties			
14. Use hearing aid			
15. Ringing in ears (tinnitus)			
16. Perforated ear drum			
17. Persistent or severe ear infection			
18. Other ear or hearing conditions			
EYES AND VISION			
19. Glaucoma			
20. Cataract			
21. Eye irritations (itching or burning)			
22. Eye infection			
23. Defective vision			
24. Color blindness			
25. Injury to eye			
26. Eye surgery			
27. Double vision			

Health Condition	*Yes*	*Year*	*N o*
28. Glasses			
29. Contact lenses			
RESPIRATORY SYSTEM (lungs & breathing)			
30. Persistent or severe colds			
31. Persistent or severe cough			
32. Coughing blood			
33. Asthma or breathing difficulty			
34. Emphysema			
35. Pneumonia			
36. Tuberculosis			
37. Other lung or breathing condition:			
CARDIOVASCULAR SYSTEM (heart & blood vessels)			
38. Heart attack			
39. Hardening of the arteries (Arteriosclerosis)			
40 High or low blood pressure			
41. Heart murmur			
42. Palpitations or irregular heart beat			
43. Episodes of chest pains, tightness, discomfort			
44. Shortness of breath			
45. Varicose veins			
46. Swelling of ankles, feet or legs (edema)			
47. Leg pains, cramps			
48. Other cardiac conditions:			
GASTROINTESTINAL SYSTEM (stomach & intestines)			
49. Persistent or severe nausea or indigestion			
50. Persistent or severe stomach pain			
51. Vomiting blood			
52. Persistent or severe vomiting			
53. Hernia (rupture)			
54. Stomach or duodenal ulcer			

Health Condition	*Yes*	*Year*	*No*		*Health Condition*	*Yes*	*Year*	*No*
55. Colitis					99. Trick or locked knee			
56. Hemorrhoids or piles					100. Knee surgery			
57. Change in bowel habits					101. Foot problems			
58. Black stool or blood in stool					102. Bone infection			
59. Persistent or severe constipation					103. Broken or fractured bone			
60. Persistent or severe diarrhea					104. Persistent or severe muscle aches or pains			
61. Pancreatitis					105. Other Musculoskeletal conditions:			
62. Appendicitis					ENDOCRINE/METABOLIC SYSTEM			
63. Other conditions of stomach or intestines					106. Diabetes			
LIVER, SPLEEN & GALLBLADDER					107. Thyroid condition or disease			
64. Cirrhosis					108. Hypoglycemia			
65. Hepatitis					109. Unexplained weight gain or loss			
66. Yellow jaundice					110. Unusual loss or growth of body hair			
67. Gallstones					111. Gout			
68. Other conditions of liver, spleen or gallbladder					112. Osteoporosis or other bone disease			
KIDNEYS & URINARY TRACT					SKIN			
69. Kidney stones					113. Rash			
70. Kidney infection					114. Hives			
71. Blood or pus in urine					115. Moles that bleed or get larger			
72. Pain or burning when urinating					116. Change in color of skin (other than suntan)			
73. Frequent urination					117. Frequent boils/abscesses			
74. Albumen or protein in urine					118. Trouble with fingernails			
75. Prostate condition					119. Small itching blisters on the side of fingers or palms			
76. Burning discharge from penis					120. Sores that do not heal			
77. Other conditions of kidneys or urinary tract					121. Other skin conditions:			
REPRODUCTIVE SYSTEM (FEMALES ONLY)					BLOOD/LYMPH (hematologic) SYSTEMS			
78. Pregnant at present					122. Anemia			
NEUROLOGICAL (Nervous) SYSTEM					123. Bleeding disorder			
79. Epilepsy, convulsions, seizures					124 Sickle cell disease or trait			
80. Periods of blackouts/loss of consciousness					125. Phlebitis/blood clot			
81. Fainting spells					126. Blood transfusion			
82. Dizzy spells (vertigo)					127. Chills, fever, night sweats			
83. Memory difficulty					128. Lymph node or glandular swelling that persists			
84. Tremor of the hands or head					129. Other conditions of blood or lymph:			
85. Paralysis of any type					CANCER			
86. Stroke					130. Surgery			
87. Severe numbness, tingling or weakness					131. Radiation therapy			
88. Dyslexia/learning difficulty					132. Chemotherapy			
89. Other conditions of neurological (nervous) system:					133. Immunotherapy			
MUSCULOSKELETAL SYSTEM					134. Hormone therapy			
90. Arthritis					135. Breast			
91. Bursitis/tendonitis					136. Bone			
92. Swollen or painful joints					137. Skin			
93. Dislocations					138. Other			
94. Painful or trick shoulder					PSYCHOLOGICAL/MOOD			
95. Elbow problems					139. mental problem requiring hospitalization			
96. Wrist or hand problems					140. Suicidal/attempted suicide			
97. Back pain					141. Active psychosis			
98. Back surgery					142. Drug, narcotic or alcohol			

Health Condition	*Yes*	*Year*	*No*		*Health Condition*	*Yes*	*Year*	*No*
143. Persistent or severe depression/worry					ALLERGIES (caused by)			
144. Other psychological conditions:					152. Medication			
INFECTIOUS OR CHILDHOOD DISEASES					147. Rheumatic fever			
Meningitis/encephalitis					153. Food			
146. Polio					154. Soaps or detergents			
148. Mumps					155. Pollen			
149. Measles					156. Insect bites/scales			
150. Venereal Disease					157. Other:			
151. Other:								

Explanation of items checked "Yes." Enter item number (1-157) before each comment.

_____

_____

_____

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B. CURRENT MEDICATIONS: _____

_____

C. SURGICAL HISTORY

Have you ever had surgery? ☐ **Yes** ☐ **No**

[If "Yes, complete the following information about each surgery]

TYPE OF SURGERY DATE (Mo/Yr)

1. _____ _____
2. _____ _____

D. HOSPITALIZATION HISTORY

Have you ever been hospitalized? ☐ **Yes** ☐ **No**

[If "Yes," complete the following information about each hospitalization.]

REASON FOR HOSPITALIZATION DATE (Mo/Yr)

1. _____ _____
2. _____ _____
3. _____ _____