City and County of San Francisco
OHS Medical History Form

1001 Potrero Avenue Building 9 Room 115
San Francisco, CA 94110

Date: _____

Please complete this form in advance and bring it with you to your medical appointment.

Employer/ Department: _____

Job Class#: _____ **Job Title:** _____ **Employee ID#** _____
(DSW or POI #)

1. **Print Name:** _____
Last *First* *MI*

2. **Address: Street:** _____

City_____ **State** _____ **Zip** _____ **County** _____

3. Telephone: Home _____ **Mobile:** _____ **Work:** _____

4. Birth Date: _____/_____/_____ **5. Ethnic Background:** _____
Month Day Year

6. Social Security # _____-_____-_____ **7. Sex:** ☐ Male ☐ Female

8. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: _____

9. Email Address: _____

10. Emergency Contact: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____ Work Phone:_____

11. Primary Care Physician: _____ Phone #: _____

Address: _____ _____ _____ _____
No. & Street *City* *State* *Zip code*

12. Do you have any current health problem(s) which **could affect your ability to do the duties of the proposed job?**

☐ YES ☐ NO If yes, please explain. _____

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13. Do you have a history of health problem(s) which **could affect your ability to do the duties of the proposed job?**

☐ YES ☐ NO If yes, please explain. _____

_____

14. Do you have any symptom(s) that **could affect your ability to do the duties of the proposed job?**

☐ YES ☐ NO If yes, please explain: _____

_____

_____

15. Are you receiving treatment from a health care provider for any physical or psychiatric medical conditions that **could affect your ability to do the duties of the proposed job?**

☐ YES ☐ NO If yes, please explain: _____

_____

_____

16. Do you have any medical restrictions that **could affect your ability to do the duties of the proposed job?** (This includes restrictions due to personal and work-related injuries or illnesses).

☐ YES ☐ NO If yes, please explain: _____

_____

_____

17. List any medications, drugs, or other health supplements that you are currently taking (both prescribing and over-the-counter) that **could affect your ability to do the duties of the proposed job.**

_____

_____

_____

I certify that all of the statements made in this questionnaire are true and complete. I understand that any misstatements of material facts may subject me to disqualification or dismissal.

Signature: _____ **Date:** _____