SOUTH CAROLINA SECOND INJURY FUND MEDICAL INQUIRY (CURRENT EMPLOYEES)

Completion of this report is requested to assist your employer in meeting the knowledge requirement of the South Carolina Second Injury Fund.

THIS QUESTIONNAIRE IS SOLELY FOR THE PURPOSE OF ENABLING YOUR EMPLOYER AND ITS INSURER TO FULFILL THE REQUIREMENTS OF THE SOUTH CAROLINA SECOND INJURY FUND. NEITHER YOUR ANSWERS TO THE QUESTIONS NOR YOUR REFUSAL TO ANSWER THEM WILL BE USED IN EMPLOYMENT ACTIONS.

Name: ______________________________ Dept.: ______________________________ Position: ______________________________

A. To the best of your knowledge do you have or have had any of the following medical problems?

		Y	N
1	**Epilepsy**		
2	**Diabetes**		
3	**Cardiac disease**		
4	**Arthritis**		
5	**Amputated foot, leg, arm or hand**		
6	**Loss of sight** of one or both eyes or partial loss of uncorrected vision of more than 75% percent bilateral		
7	**Residual disability from Poliomyelitis**		
8	**Cerebral palsy** – Do you have a weakness or stiffness of arms, legs or other body parts that resulted from birth, injury or disease? Any spasticity?		
9	**Multiple sclerosis**		
10	**Parkinson's disease**		
11	**Cerebral vascular accident** – Stroke or ruptured blood vessel in the head		
12	**Tuberculosis**		
13	**Silicosis** – Chronic cough emphysema or other lung problems due to inhalation of dust		
14	**Degenerative Disc Disease**		
15	**Mental retardation**		
16	**Psychoneurotic disability** which involved treatment in a recognized medical or mental institution		
17	**Chondromalacia**		
18	**Hemophilia** – do you bleed easily and have a hard time stopping the bleeding?		
19	**Spondylosis**		
20	**Spondylolisthesis**		
21	Cancer		

		Y	N
22	**Hyperinsulinism** – Excessive insulin in the blood with low blood sugar and periods of weakness or fainting due to low blood sugar		
23	**Muscular dystrophy**		
24	**Arteriosclerosis** - Poor circulation, cold extremities, pain in legs while walking		
25	**Thrombophlebitis** – Infection or inflammation of veins in legs – swelling or tenderness in calves of legs		
26	**Varicose veins**		
27	**Heavy metal poisoning**		
28	**Ionizing radiation injury** – Have you been exposed to radiation and have developed sores that did not heal, vomited or bled freely?		
29	**Compressed air sequelas** – Have you ever had the bends? Problems produced by flying at high altitude or problems resulting from exposure to high atmospheric pressure as in scuba diving?		
30	**Ruptured disc**		
31	**Hodgkin's disease**		
32	**Brain damage**		
33	**Deafness**		
34	**Chronic osteomyelitis** – Long-term infection of bones or sores of the skin		
35	**Sickle-cell anemia**		
36	**Pulmonary disease**		
37	Have you suffered from any other pre-existing disease, condition or impairment that is permanent in nature? (If yes, please explain on back of form.)		
38	**HIV**		
39	**Ankylosis** of joints – Joints that are stiff and will not fully move. Frozen joints		

If you listed **ARTHRITIS**, please identify which parts of the body affected:

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For “yes” responses above, indicate the nature of injury or illness and name of physician in Remarks Section:
Remarks:

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A. Have you ever been assessed any percentage of permanent disability to any part of your body for any reason whatsoever?

☐ YES☐ NO

If so, please explain:

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B. Have you ever had surgery to any part of your body that has led to a permanent impairment?

☐ YES☐ NO

If yes, please list the part(s) of the body operated on, the type of operation performed, the date of the operation, the name of the hospital, if any, where the operation was performed, and the name, address and phone number of the doctor performing the surgery.

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ACKNOWLEDGMENT AND RECORDS RELEASE

I understand this questionnaire is solely for the purpose of enabling my employer and its insurer to fulfill the requirements of the South Carolina Second Injury Fund. Neither my answers to the questions nor my refusal to answer them will be used against me or considered in employment action. The information provided is true to the best of my knowledge and belief. In the event of a future work related accident, my employer is authorized to request and review medical records pertaining to any of the conditions described herein as well as any records maintained by any government agency, past employer, doctor or treatment facility with respect to any personal injuries I have received. I agree that a photocopy of this authorization may be used instead of the original.

NAME (Print or Type): ____

SIGNATURE: ______________________________ **Date:** ______________

Employees who do not wish to share any information concerning their health or physical condition please sign and date below.

I do not wish to fill out the questionnaire. I understand that my election not to fill out the questionnaire will not be used against me or considered in employment action.

NAME (Print or Type): ____

SIGNATURE: ______________________________ **Date:** ______________