

SOUTH CAROLINA POST-OFFER-OF-EMPLOYMENT MEDICAL INQUIRY

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 sequelae – 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:

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

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:

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.

C. Have you ever had an injury that required you to miss time from work?

YES NO

IF YES, PLEASE INDICATE THE TYPE OF INJURY, THE AMOUNT OF TIME MISSED FROM WORK, WHETHER THE CONDITION WAS FULLY RESOLVED OR IF IT LEFT YOU WITH ANY IMPAIRMENT, AND WHETHER YOU RETURNED TO WORK.

ACKNOWLEDGMENT AND RECORDS RELEASE

I understand this questionnaire is for the purpose of enabling my employer to fulfill the requirements of the South Carolina Second Injury Fund, and it is in no way connected to the employer's decision to hire me. The information provided is not to be used by the employer as a basis of denying me placement or promotion, or to discriminate against me in any way. 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: _____