

**Iowa Vocational Rehabilitation Services
Health Assessment Questionnaire**

Name: _____

Reported Medical History			Explain any "Yes" answers (problem - who treated - when)
I have had:	Yes	No	
1. PROBLEMS WITH EYES, EARS, NOSE, THROAT	<input type="checkbox"/>	<input type="checkbox"/>	
2. DIZZINESS, FAINTING, BLACKOUT, CONVULSIONS STROKE, PARALYSIS, FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	
3. A HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	
4. PERSISTENT BRONCHITIS, ASTHMA, EMPHYSEMA, TUBERCULOSIS, OR OTHER PROBLEMS WITH CHEST OR LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	
5. HIGH BLOOD PRESSURE, CHEST PAIN, HEART ATTACK, RHEUMATIC FEVER, HEART MURMUR, OR OTHER PROBLEMS WITH HEART OR BLOOD VESSELS	<input type="checkbox"/>	<input type="checkbox"/>	
6. ULCER, HERNIA, COLITIS, INTESTINAL BLEEDING, OR OTHER PROBLEMS WITH STOMACH, INTESTINES, LIVER, OR GALL BLADDER	<input type="checkbox"/>	<input type="checkbox"/>	
7. PROBLEMS WITH KIDNEYS, BLADDER, PROSTATE, REPRODUCTIVE ORGANS OR VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	
8. DIABETES, THYROID, PITUITARY, ADRENAL, OR OTHER GLAND PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	
9. ARTHRITIS, LOW BACK PAIN, OR OTHER PROBLEMS WITH SPINE, BACK OR JOINTS	<input type="checkbox"/>	<input type="checkbox"/>	
10. LOSS OR PARALYSIS OF LIMB OR OTHER BODY PARTS	<input type="checkbox"/>	<input type="checkbox"/>	
11. TUMORS, LEUKEMIA, OR CANCER	<input type="checkbox"/>	<input type="checkbox"/>	
12. ALLERGIES, ANEMIA, SKIN CONDITIONS	<input type="checkbox"/>	<input type="checkbox"/>	
13. MENTAL OR EMOTIONAL CONDITIONS	<input type="checkbox"/>	<input type="checkbox"/>	
14. PROBLEMS WITH READING, ARITHMETIC, WRITING, OR SPEECH	<input type="checkbox"/>	<input type="checkbox"/>	
15. PROBLEMS WITH ALCOHOL OR DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	
16. TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITIONS	<input type="checkbox"/>	<input type="checkbox"/>	
17. PRESCRIPTIONS FOR ANY DRUGS OR MEDICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	
18. A BRACE, PROSTHESIS, HEARING AID, OR OTHER DEVICE	<input type="checkbox"/>	<input type="checkbox"/>	

My recent medical records may be obtained from:

Name of Physician/Hospital	Address	Date of Last Exam	Reason

In order to better understand your vocational needs, please review the following areas and check those areas that create difficulty for you in obtaining or maintaining employment.

1. MOBILITY

- Walking Kneeling Twisting Climbing Crouching Stooping
 Balancing Crawling Travel
 Other _____

2. SELF CARE

- Eating Child Care Medication Management Hygiene
 Housekeeping Money Management Laundry Toileting
 Shopping Cooking Dressing Using the Telephone
 Grooming Independent Living Self-injurious behavior
 Repeat Hospitalization
 Other _____

3. SELF DIRECTION

- Dependability Judgment Planning Activities Following Routine
 Frequent Changes Initiating Activities Making Decisions
 Being Punctual Being Organized
 Other _____

4. WORK SKILLS

- Memory Attention Span Comprehension Learning Speed
 Quantitative Skills Motor Coordination Manual Dexterity
 Eye/hand Coordination Manipulates Objects Spatial/Time Management
 Other _____

5. WORK TOLERANCE

- Stamina Strength Temperature Change Cold/Heat
 Hazards Noise/Vibrations Fumes/Dust Work Speed
 High Places Wet/Humid Environment Sitting Reaching
 Chemical Sensitivity Psychological Factors Stress Standing
 Absenteeism Lifting (lbs., specifics) _____
 Other _____

6. INTERPERSONAL SKILLS

- Cooperation Getting along with others Controlling Emotions
 Tact/Diplomacy Understanding Social Cues Accepting Supervision
 Social Withdrawal
 Other _____

7. COMMUNICATION

- Speaking Reading Hearing Writing Interviewing
 Other _____