VOLUNTEER
Health Questionnaire

Springfield Memorial Hospital

Last name | First name | Middle initial

Address | City | State | ZIP

Phone | Cell | Birth date

Please complete the following questions:

1. Do you wear corrective lenses? ☐ **Yes** ☐ **No**
2. Do you wear a hearing aid? ☐ **Yes** ☐ **No**
3. Are you presently under the care of physician(s)? ☐ **Yes** ☐ **No**

   If yes, please explain: _____
4. Is your physical activity limited in any way? ☐ **Yes** ☐ **No**

   If yes, please explain: _____
5. Do you take any medications on a regular or as-needed basis? ☐ **Yes** ☐ **No**

   If yes, please explain: _____
6. Have you ever had an operation? ☐ **Yes** ☐ **No**

   If yes, please give dates and types of surgery: _____
7. Do you have a history of the following diseases?

	NEVER	PRESENTLY	IN THE PAST	UNSURE
Rubella (German, 3-day measles)				
Rubeola (long, hard, red measles)				
Mumps				
Chickenpox (if no, see #8)				
Tuberculosis				
Hepatitis B				

8. Have you ever been vaccinated for the following diseases?

	YES	NO	DATES (IF YES)		
Hepatitis B			#1	#2	#3
Tetanus/diptheria			#1		
Chickenpox			#1	#2	
German measles (Rubella)*			#1		

CONTINUED

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	YES	NO	DATES (IF YES)		
Measles (Rubeola)*			#1		
Mumps*			#1		

**ADULTS BORN BEFORE 1957 ARE USUALLY CONSIDERED IMMUNE, BUT PROOF OF IMMUNITY SHOULD BE CONSIDERED FOR HEALTHCARE WORKERS.*

9. **Do you have a history of the following?**

	NEVER	PRESENTLY	IN THE PAST	UNSURE
Heart disease or heart attack				
Rapid, slow or irregular heartbeat				
Stroke				
High blood pressure				
Varicose veins, blood clots				
Shortness of breath while walking on level ground				
Emphysema				
Asthma				
Epilepsy, seizure disorder				
Fainting spells, dizziness				
Parkinson's disease				
Arthritis, painful or swollen joints				
Back problems or back surgery				
Hernia (rupture)				
Diabetes				

10. **Do you have any serious or life-threatening allergies?** ☐ **Yes** ☐ **No**

If yes, please explain: _____

I hereby affirm that the information on this health questionnaire is true and correct to the best of my knowledge.

Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN

Based on the information provided above and the patient's file, I certify _____ is physically able to be a volunteer at Springfield Memorial Hospital.
PATIENT NAME

Restrictions: _____

Physician name _____ Phone _____

Physician signature _____ Date _____