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STATE OF CALIFORNIA − DEPARTMENT OF HUMAN RESOURCES

CONFIDENTIAL MEDICAL DOCUMENT

HEALTH QUESTIONNAIRE

(And Physician's Report)

STD. 610 (Rev. 10/2019)

STATE LAW AND THE AMERICANS WITH DISABILITIES ACT REQUIRE APPLICANTS TO FILL IN QUESTIONS ON PAGES 1 AND 2 OF THIS FORM **ONLY AFTER A JOB OFFER HAS BEEN MADE**

DATE JOB OFFER MADE

THIS AREA TO BE COMPLETED BY HIRING AGENCY — COMPLETED QUESTIONNAIRE TO BE RETURNED TO HIRING AGENCY

APPLICANT NAME *(Last)*	*(First)*	*(Middle)*		HIRING AGENCY NAME
APPLICANT ADDRESS *(Number and Street)*	*(City)*	*(State)*	*(Zip Code)*	AGENCY ADDRESS

CLASS TITLE OF VACANCY	POSITION NUMBER OF VACANCY	HIRING MANAGER	PHONE NUMBER

APPOINTMENT TYPE

☐ PERMANENT ☐ TAU ☐ LIMITED TERM ☐ PEACE OFFICER

☐ REINSTATEMENT *(if reinstatement, enter dates of previous State Employment.)*

DESIRED APPOINTMENT DATE | CERTIFICATION NUMBER

CURRENT OCCUPATION

THIS AREA TO BE COMPLETED BY THE APPLICANT ONLY AFTER A JOB OFFER HAS BEEN MADE

DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLEARANCE IS REQUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE.

Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form.

BIRTHDATE	☐ MALE ☐ FEMALE	EMAIL	PHONE NUMBER

For questions 1 - 43, have you ever had or do you have the following:

ITEM	YES	NO
1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma	☐	☐
2. Residuals of poliomyelitis	☐	☐
3. Hepatitis, jaundice, or other liver ailments	☐	☐
4. Cancer, malignant tumor, or cysts	☐	☐
5. Diabetes or sugar in urine	☐	☐
6. Pernicious anemia, leukemia, or other blood disorder or ailment	☐	☐
7. Mental illness	☐	☐
8. Any disorder of the nervous system	☐	☐
9. Seizure disorder or loss of consciousness	☐	☐
10. Severe headaches or migraine	☐	☐
11. Heart trouble--including circulatory disease	☐	☐
12. Rheumatic fever	☐	☐
13. Any defect of bones or joints, including amputations, dislocations, or broken bones	☐	☐
14. Rheumatism, arthritis, or bursitis	☐	☐
15. Back pain or back injury	☐	☐
16. Head injury	☐	☐
17. Any problems with hips, knees, ankles, or feet	☐	☐
18. Any problems with hands, elbows, or shoulders	☐	☐
19. Fainting spells or dizziness	☐	☐
20. Skin rash from work	☐	☐
21. Allergies	☐	☐
22. Sensitivity to dust or smoke	☐	☐
23. High or low blood pressure	☐	☐
24. Varicose veins	☐	☐
25. Stomach or duodenal ulcer or other bowel problem	☐	☐

ITEM	YES	NO
26. Rupture or hernia	☐	☐
27. Gall bladder trouble	☐	☐
28. Kidney or bladder trouble	☐	☐
29. Shortness of breath	☐	☐
30. Any speech impairment	☐	☐
31. History of addiction to drugs or alcohol	☐	☐
32. Do you wear or have you ever worn glasses?	☐	☐
33. Do you or have you ever worn contact lenses?	☐	☐
34. Have you had any eye injury, surgery, or disease?	☐	☐
35. Are you blind in one eye?	☐	☐
36. Are you blind in both eyes?	☐	☐
37. Do you wear hearing aid or have you had at any time a problem with your hearing?	☐	☐
38. Do you have any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2.	☐	☐
39. Are you at present under a doctor's care for any condition? Give reason and doctor's full name and address	☐	☐
40. Are you taking any medication now or in the last 12 months? If yes, what?	☐	☐
41. Have you ever been hospitalized? If yes, list reason and date of hospitalization.	☐	☐
42. a. Have you had an illness or injury which caused you to lose time from work?	☐	☐
b. Does this illness or injury continue to limit your ability to perform certain types of work?	☐	☐
43. Have you ever had any other illness, injury or physical condition not named above *(exclude minor problems such as colds, flu, etc.)*?	☐	☐

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APPLICANT NAME *(Last)*	*(First)*	*(Middle)*	HIRING AGENCY NAME

Please write your own account and your own evaluation of all items to which you have answered "YES" to the prior questions. Include DATE OF ONSET, YOUR PRESENT CONDITION AS YOU EVALUATE IT and what accommodations to your limitations, if any, you feel you may require to perform satisfactorily the duties of the position for which you are applying without endangering the health and safety of yourself or others. **Return this completed form to the hiring agency unless advised otherwise by the hiring agency. Follow their instructions for submission.**

Item #	Explanation of "YES" Items	Healthcare Provider and Contact Information

CERTIFICATION: I certify that I have provided true and complete information concerning my fitness.
(Any misrepresentation or material omission may be cause for dismissal.)

APPLICANT'S SIGNATURE	DATE SIGNED	PHONE NUMBER

EXAMINING PHYSICIAN'S COMMENTS:

PHYSICIAN'S SIGNATURE *(MD or DO only)*	DATE SIGNED	

DO NOT WRITE BELOW THIS LINE - DELEGATED AUTHORITY OR CALIFORNIA DEPARTMENT OF HUMAN RESOURCES OFFICER ONLY

REVIEWER ☐ APPROVED ☐ DISAPPROVED ☐ SUBJECT TO PROPER PLACEMENT

CalHR's MEDICAL OFFICER'S SIGNATURE	DATE SIGNED	

CalHR's MEDICAL OFFICER'S NAME *(Typed or Printed)*

STATE OF CALIFORNIA − DEPARTMENT OF HUMAN RESOURCES

HEALTH QUESTIONNAIRE
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(To be completed by a licensed physician and surgeon only after a job offer has been made)

TO THE PHYSICIAN: The attached Health Questionnaire must be completed and submitted to you by the person whose name appears below. It is intended to assist you in conducting the examination. You are requested to complete the medical examination report. **The Hiring Agency is responsible for payment of the fee. See page 4 for instructions.**

ALL ITEMS BELOW ARE MANDATORY--COMPLETED REPORT SHOULD BE RETURNED TO HIRING AGENCY

APPLICANT NAME *(Last)*	*(First)*	*(Middle)*	HIRING AGENCY NAME

DOCTOR: Write comments on any positive or negative findings for evaluation of applicant. *(If more space is needed, use reverse of this form and/or a separate sheet of paper.)* Examine color vision only when required in Minimum Qualifications.

JOB CLASSIFICATION/TITLE

1. MEASURED HEIGHT
2. MEASURED WEIGHT
3. BLOOD PRESSURE

If high, second reading: BLOOD PRESSURE

4. PULSE

PULSE

VISION ☐ Glasses ☐ Contact Lenses

5. PERIPHERAL VISION

Right _____ °

Left _____ °

VISUAL ACUITY

6.

	UNCORRECTED Near	UNCORRECTED Distant	CORRECTED Near	CORRECTED Distant
Right 20/				
Left 20/				
Both 20/				

COLOR VISION *(If required)*

7. ISHIHARA COLOR VISION RESULTS

☐ Normal ☐ Abnormal

_____ / _____

Plates Correct / # of Plates Tested

8. HEARING
(Ordinary conversation at 15 feet considered normal)

Right ____/15 Left ____/15

HEARING AID USED ☐ YES ☐ NO

AUDIOMETRY *(If required)*

	500	1000	2000	3000	4000	6000
Right						
Left						

9. URINALYSIS:

Specific Gravity	
Protein/Albumin	
Sugar	

10. HEAD *(Eyes, ears, TMs, oropharynx)*
11. GENITOURINARY *(Note any CVA tenderness)*
12. HEART *(Rhythm, murmurs, size, thrust)*
13. NERVOUS SYSTEM *(Romberg sign, reflexes, motor strength, sensory changes)*
14. LUNGS *(Breath sounds, wheezing, rales)*
15. SPINE *(Appearance, deformity, tenderness, ROM)*
16. ABDOMEN *(Tenderness, masses, obesity, inguinal, ventral, or umbilical hernia)*
17. UPPER EXTREMITIES *(Strength, ROM, deformity, sensory changes)*
18. SKIN AND LYMPHATICS *(Scarring, erythema, edema)*
19. LOWER EXTREMITIES *(Strength, ROM, deformity, sensory changes)*
20. PSYCHIATRIC *(Any abnormality noted, affect, mood, speech)*
21. VARICOSE VEINS / OTHER VASCULAR ABNORMALITY *(Mild, moderate, severe)*
22. ANY WORK LIMITATION *(You should review job description/duties) Specify any limitations or needs.*

23. PHYSICIAN'S SIGNATURE *(Required MD/DO Only)*

24. DATE SIGNED

PHYSICIAN'S STAMP *(Must Include Address and Phone)*

MUST BE SIGNED/CO-SIGNED BY PHYSICIAN.

25. PHYSICIAN'S NAME *(Typed or Printed)*

PHYSICIAN'S ADDRESS *(Required or Use Stamp)*

PHYSICIAN'S PHONE NUMBER *(Required or Use Stamp)*

NOTICE TO PHYSICIANS AND CLINICS

The State of California requires preplacement physical examinations for certain classes of employment. The State also has many employees who are required to have a physical examination at the time of renewal of their Class I or II driver's license, when the possession of the license is required for the position. If the hiring agency is not identified, do not perform the examination. The California Department of Human Resources does not have the authority to pay for examinations. Please review medical history and comment and sign on Page 2. Also please comment and sign on Page 3.

REPORTS

The medical report should be sent to the Hiring Agency shown on Page 1.

BILLINGS

Please send your bill for this examination to the Hiring Agency as indicated on Page 1. Include your Federal Employer Identification Number or Social Security Number for tax reporting purposes. The State Hiring Agency will pay the fee for this Medical Examination Report up to a maximum determined by the Department of Health Care Services and set forth in the State Administrative Manual (Section 192). The current fee allowance may be obtained from the Hiring Agency shown on Page 1. If there should be additional studies or examinations required for more complete evaluation of the individual, these examinations will be at the expense of the applicant.

PRIVACY NOTICE

Official Responsible: Medical Officer, California Department of Human Resources, 1515 S Street, North Building, Suite 500, Sacramento, CA 95811; Authority: Government Code Section 18931; Purpose: The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; Providing Information: Medical clearance is required prior to employment in state service; Effects of Not Providing Information: Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous. A misrepresentation or omission may be cause for adverse employment action; Access: Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.