

OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
GENERAL HEALTH CHECKLIST

Full Name _____ Social Security Number _____

Date of Birth _____ Height _____ Weight _____

**IF YES, HAS IT
 KEPT YOU FROM
 WORKING?**

Please answer "Yes" or "No" to all items.

Do you have. . . .	YES	NO	YES	NO
1. A disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Frequent dizziness, fainting, or headache; seizures, convulsions, paralysis, or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of your lungs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver, or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Disorder of kidney, bladder, prostate or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes, thyroid, or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Arthritis or other disorder of the muscles or bones, including the spine, back or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Absence or amputation of any body part?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Loss of use of arms and legs or other body part?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. A tumor, cancer, or disorder of skin or lymph glands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Excessive use of alcohol or any habit-forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Any other physical or mental condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, specify: _____

17. Name and address of your personal physician/clinic: (if none, so state)

PLEASE ANSWER THESE QUESTIONS FOR ANY CONDITION MARKED "YES" ON THE FIRST PAGE:

18. Have you been or are you being treated for any of these conditions? YES NO

If **No**, why not? _____

If YES , Condition	Dr. Name & Address	Phone Number	Dates Seen
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

19. Have you been hospitalized for any of these conditions? YES NO

If YES , Condition	Hospital	When?
_____	_____	_____
_____	_____	_____
_____	_____	_____

20. Are you taking any medicines? YES NO

If YES, Condition	Medicine	Condition	Medicine
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

21. Do you have any restrictions from these conditions? YES NO

If YES, Condition	What restrictions?
_____	_____
_____	_____
_____	_____

To the best of my knowledge, what I have said is true and I have not withheld any information.

(Date)

(Signature of applicant)

Person who provided information, if not applicant: _____

Comments: _____

Once you complete the application, please print it out. Check to see that all three (3) pages printed.

Call for an appointment and bring the application with you, along with any pertinent medical records.

To find the nearest office, call 1-800-487-4042.