

November 30, 2009

Thank you for your interest in employment with Volkswagen Group of America (VWGoA). We recently contacted you to schedule your testing related to the next phase of the VWGoA Team Member selection process.

The Volkswagen Health Assessment requires you to participate in a pre-placement medical examination. Your medical examination is scheduled as follows:

Test Date: _____

Test Time: _____

Testing Location:

Volkswagen Assessment Center

7801 Lee Highway

Chattanooga, TN 37421

The medical examination is very comprehensive and takes approximately four (4) hours to complete. The exam will include lab work requiring you to fast for eight (8) hours prior to your scheduled test time. There will be a vending machine available at the test site for you to purchase a snack after the lab work is complete, or please bring a snack with you. We recommend that you eat something prior to starting the functional assessment portion of the exam. If you have a medical condition which would preclude you from fasting, please proceed with your normal eating schedule. In this event, please be sure to bring your medical records documenting this condition.

For the examination process to flow smoothly there are several items you will need to complete and bring with you to the medical exam.

1. Personal Medical History Questionnaire (PMHQ)
2. Occupational Exposure History Questionnaire (OccExpHQ)
3. Instructions for Completing Medical History Assessment

Please read and follow the attached instructions when completing these forms. ***All forms must be completed using black or blue ink. Please bring with you any medical records related to any condition that you've received treatment for within the past five (5) years.***

You will also be required to sign a Release of Medical Information (RoMI) to enable WorkForce Progressive Health to release the results of your examination to VWGoA. WorkForce Progressive Health will evaluate the results of the examination and advise VWGoA of your medical examination status. VWGoA has the sole responsibility for final employment determination.

Again, we want to emphasize ***this offer of employment is contingent upon your health assessment. If you are currently employed, please do not terminate your employment at this time.***

If you have any questions concerning the selection process, please contact the Volkswagen Assessment Center at VWGoA.

Thank you in advance for your sincere interest in a future with Volkswagen Group of America and good luck as you proceed along another phase of our selection process.

Sincerely,

Mario Duarte
Assistant Manager
HR Staffing & Planning
www.vwgroupcareers.com



Post-Offer, Pre-Employment Screen Consent Form

Candidate Name: _____

By placing my signature upon this document, I hereby agree to participate in a post-offer, pre-employment screen to be conducted by ProgressiveHealth (PHR). This screen has been requested by Volkswagen Group of America (VWGoA); however, I understand that I am not obligated by PHR or Volkswagen to participate. My decision to participate in this test is voluntary.

I will be requested to perform tests which will enable the medical staff to assess and evaluate my posture, flexibility, strength, safe lifting capacity, and other anticipated job-specific tasks that have been described to me by PHR personnel. I understand that these tests will be administered by licensed health care providers, and by trained personnel of their choice under the direction of the licensed medical staff. I understand that the test follows safe, established protocols and that the staff is trained to safely provide and monitor the testing procedures.

I agree to follow all instructions given to me during the testing process, and to notify the therapist or technician if I do not understand the instructions. I understand that it will be necessary to put forth my maximum safe effort during the testing and feel as if I am able to do so.____(INT) I acknowledge that the performance of this screen will entail certain risks and physiological changes that could cause light-headedness, fainting, musculoskeletal injury, back discomfort, shortness of breath, and in extremely rare cases palpitations, heart attacks, or more serious complications.____(INT) I agree to notify the therapist or technician if I feel any pain or discomfort during the performance of the test. I understand that the test may be discontinued at any time due to signs of discomfort or feelings of faintness. I further agree to hold PHR and Volkswagen harmless, except with proof of gross negligence, if I do incur any injury during testing procedures.____(INT)

I have been given an opportunity to ask questions about my present physical condition and about the physical tests to be performed, and I believe that I have sufficient information to give this informed consent. I certify that I have been advised of my right to request any reasonable accommodation needed because of disability and that I have no medical or other conditions or limitations to my performing these physical tests.____(INT)

I certify that this form has been fully explained to me, that I have read it or had it read to me, that the blank spaces have been filled in, and that I understand its contents. I understand that if a medical risk is found that could affect my ability to perform the job safely, physician consent by a qualified specialist will be necessary. I understand and authorize PHR to forward such forms to Volkswagen to give to me. Furthermore, I understand and authorize PHR to forward medical information, the medical history, and test results to Volkswagen who may utilize the overall results of the post-offer screen to determine whether or not to hire me and to place me in a specific employment position. I specifically release PHR and Volkswagen of any liability that could result from the use of these results by the Volkswagen in making any decisions regarding my present or prospective employment.

Finally, I authorize the PHR to utilize and publish results of the screen in its research and collection of data concerning industrial employees.

CONSENT TO TAKING OF PHOTOGRAPHS

I hereby authorize the PHR and associates or assistants to take photographs of me as a part of the requested screen. These photographs shall be used for identification purposes only. In the event that I might subsequently become injured, I agree that these photographs may be used in a confidential manner as a part of the medical records.

Signature

Date

Signature of Witness

Date

INSTRUCTIONS FOR COMPLETING MEDICAL HISTORY

Completion of the Personal Medical History Questionnaire and the Medical Release of Information is a part of the Volkswagen Group of America (VWGoA) physical examination process. *The physical examination process includes:* review of the completed Personal Medical History Questionnaire (PMHQ), physical ergonomic assessment, physical examination by a doctor, diagnostic laboratory testing, vision test, hearing test, lung capacity test, neurological diagnostic testing, and a urine drug screen. The information which you provide herein will be used to determine that you can perform your job safely and effectively.

Enclosed you will find the following documents:

1. Personal Medical History Questionnaire (PMHQ)
2. Authorization for Release of Medical Information (RoMI) To be used when you are requesting medical records associated with a previous injury/illness.
3. Medical Record Release Form (MRRF)

Personal Medical History Questionnaire

Please read each question carefully and answer each question completely and accurately. You must account for any injury or illness you have had in your lifetime. A complete and full description of each injury/illness is required. The description must include exactly how the injury/illness occurred, the extent of the injury/illness, the part(s) of the body affected, the amount and length of recovery, the current status of the condition, and name(s) of treating health care providers.

In addition to the completion of the Personal Medical History Questionnaire (PMHQ) you must provide medical records for any injury or illness you have experienced during the past five years. For example:

1. Description of each initial injury/illness (example: fracture, pulled muscle, sprain, etc.)
2. Complete course of injury/illness including diagnosis, prognosis, treatment, and any restrictions/limitations regarding any injury/illness.
3. Please attach additional sheets if required to explain any injury/illness.

You must obtain all medical records, including any physical/vocational rehabilitation records, associated with any injury/illness you have experienced within the past 5 years. This does not include the common cold or flu.

Please read the following statement carefully, sign and date below:

All of the information I have provided is true, correct, and complete to the best of my knowledge. I agree that any omission, misrepresentation or falsification of information relating to the physical examination process will result in the withdrawal of my conditional job offer or discharge if I am employed by Volkswagen Group of America.

Signature _____

Social Security Number _____--____--_____

Date _____

MEDICAL EXAMINATION INSTRUCTIONS

(PLEASE READ CAREFULLY PRIOR TO SCHEDULED EXAM DATE)

1. Upon arrival at the VWGoA Assessment Center, please use the main entrance and report to the reception area. You will be required to present a current driver's license to verify identification. If your driver's license does not include photo identification, you must provide some other form of photo identification.
2. Avoid loud noise for at least 14 hours prior to the examination (example: loud music, firearms, machinery, etc.). If you cannot avoid loud noise, be sure to wear hearing protection while exposed to the noise source.
3. Bring in the names of all medication currently used or used during the previous two months. Include prescription, all over-the-counter medications, supplements, or anything else ingested other than food or water in a listed written form.
4. Bring prescription eyeglasses or contact lenses you may use, even if used rarely. Contact lens wearers should bring solution and case.
5. ***Important:*** Wear loose fitting, comfortable clothing.

Men: T-shirt, gym shorts and athletic shoes
Women: T-shirt, sports bra, gym shorts and athletic shoes
6. Be on time for your scheduled appointment!
7. You must obtain all medical records, including any physical/vocational rehabilitation records, associated with any injury/illness you have experienced within the past 5 years. This does not include the common cold or flu.

The medical records must include:

- Full description of all injuries or illnesses.
- Onset of condition(s), diagnosis, complete course of treatment, prognosis, medications prescribed and any resulting restrictions/limitations.



**Volkswagen Group of America (VWGoA)
Medical Record Release Form**

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DATE: ____/____/____

I HEREBY AUTHORIZE ERLANGER MEDICAL CENTER AND PROGRESSIVEHEALTH, TO RELEASE MY HEALTH EXAMINATION RECORDS TO VOLKSWAGEN GROUP OF AMERICA (VWGoA) REGARDING MY JOB APPLICATION.

I UNDERSTAND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION BY ME (US) AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. I ALSO UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE SIXTY (60) DAYS FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED. (DATE EVENT OR CONDITION ON WHICH AUTHORIZATION WILL EXPIRE IF OTHER THAN 60 DAYS): _____

PLEASE USE MY SIGNATURE BELOW AS AUTHORIZATION FOR THE RELEASE OF MY HEALTH EXAMINATION RECORDS:

SIGNATURE OF CANDIDATE: _____

DATE: ____/____/____

SIGNATURE OF WITNESS: _____



NOTICE: FALSIFICATION or WITHHOLDING OF INFORMATION regarding this medical questionnaire could result in withdrawal of the offer of employment or termination of benefits should a work-related injury ever occur.

Name: _____ **Date:** _____
Previous Job: _____ **FROM:** _____ **TO:** _____
Job Position / Company
Previous Job: _____ **FROM:** _____ **TO:** _____
Job Position / Company
Cardiovascular Activities: _____ **X/wk:** _____

HAVE YOU HAD ANY PHYSICAL DIFFICULTIES PERFORMING YOUR PREVIOUS JOBS? YES NO
HAVE YOU EVER HAD ANY WORK-RELATED ACCIDENTS? YES NO
WAS IT A LOST-TIME ACCIDENT? YES NO
 Date: _____ Explain: _____ DURATION: _____
 Medical Treatment received: _____
 Painful Now? YES NO Released from Doctor's care without restrictions? YES NO Date Released: _____

HAVE YOU EVER SEEN ANY DOCTORS, CHIROPRACTORS, PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS OR OTHER HEALTH CARE PROVIDERS FOR ANY MUSCULOSKELETAL INJURIES (I.E. SPRAINS/STRAINS)? YES NO PREVIOUSLY DISCUSSED
 Date: _____ Explain: _____ DURATION: _____
 Medical Treatment received: _____
 Painful Now? YES NO Released from Doctor's care without restrictions? YES NO Date Released: _____

HAVE YOU EVER RECEIVED ANY CHIROPRACTIC CARE? YES NO
 Date: _____ Explain: _____ DURATION: _____
 Medical Treatment received: _____
 Routine? YES NO
 Painful Now? YES NO Released from Doctor's care without restrictions? YES NO Date Released: _____

HAVE YOU EVER BEEN HURT IN ANY MOVING VEHICLE ACCIDENTS? YES NO PREVIOUSLY DISCUSSED
 Date: _____ Explain: _____ DURATION: _____
 Medical Treatment received: _____
 Painful Now? YES NO Released from Doctor's care without restrictions? YES NO Date Released: _____

HAVE YOU EVER EXPERIENCED ANY OTHER INJURIES, ACCIDENTS, OR TRAUMAS TO YOUR BODY THAT REQUIRED TREATMENT BY ANY HEALTH CARE PROVIDER? YES NO PREVIOUSLY DISCUSSED
 Date: _____ Explain: _____ DURATION: _____
 Medical Treatment received: _____
 Painful Now? YES NO Released from Doctor's care without restrictions? YES NO Date Released: _____

HAVE YOU HAD ANY SURGERIES OR OPERATIONS OF ANY KIND? YES NO PREVIOUSLY DISCUSSED
 TYPE: _____ DATE: _____
 TYPE: _____ DATE: _____
 Released from Doctor's care without restrictions for surgeries or operations? YES NO Date Released: _____

ARE YOU PREGNANT? YES NO
HAVE YOU BEEN A RECENT BLOOD OR PLASMA DONOR (Past 72 HRS)? YES NO
DO YOU TAKE ANY MEDICATIONS? YES NO
 List, if any: _____

IS THERE ANY OTHER PERSONAL MEDICAL HISTORY WE SHOULD KNOW ABOUT? (asthma, carpal tunnel, ganglion cysts, "tennis elbow", diabetes, glaucoma, vision deficit, hearing deficit, hemorrhoids, hernias, high blood pressure, low blood pressure, fainting, seizures, tightness or pain in the chest, cancer, anxiety disorder, depression)

ARE YOU CURRENTLY UNDER ANY DOCTOR'S CARE? YES NO
 Explain: _____

DO YOU NEED ANY ACCOMODATION IN ORDER TO BE ABLE TO PERFORM THE PHYSICAL REQUIREMENTS OF THE TEST?
 Explain: _____

IS THERE ANY OTHER INFORMATION, IMPAIRMENTS, OR CURRENT RESTRICTIONS WE SHOULD KNOW ABOUT PRIOR TO TESTING?
 Explain: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ DATE _____ SIGNATURE OF WITNESS _____ DATE _____



**Volkswagen Group of America (VWGoA)
Personal Medical History Questionnaire
Occupational Exposure History**

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

OCCUPATIONAL EXPOSURE HISTORY

HAVE YOU EVER WORKED ON A JOB, OR HAD A HOBBY, WHICH EXPOSED YOU TO ANY OF THE SUBSTANCES OR CONDITIONS LISTED BELOW. THE EXPOSURE COULD HAVE BEEN AS A RESULT OF BREATHING, TOUCHING, OR SKIN CONTACT. IF YOU BELIEVE YOU HAVE EXPERIENCED SUCH EXPOSURE, PLEASE CHECK YES IN THE EXPOSURE BOX OF THE FORM BELOW.

PLEASE ENTER THE APPROPRIATE CODE IN THE SPACE DEFINED AS "CODE" IN THE EXPOSURE BOX IN THE FORM BELOW.

	<u>Code</u>
OCCUPATIONAL EXPOSURE:	O
HOBBY EXPOSURE:	H
FARM EXPOSURE:	F

IF AS A RESULT OF YOUR EXPOSURE YOU EXPERIENCED A REACTION, PLEASE CHECK REACTION IN THE EXPOSURE BOX IN THE FORM BELOW AND DESCRIBE THE TREATMENT IN THE DESCRIPTION BOX.

<u>LIST OF EXPOSURES</u>	<u>EXPOSURE</u>			<u>DESCRIPTION OF REACTION</u>
	<u>YES</u>	<u>CODE</u>	<u>REACTION</u>	
FUMES (PLASTIC)				
FUMES (WELDING OR OTHER)				
DUST (FLOUR, COAL)				
ASBESTOS				
SOLVENTS, THINNERS, ALCOHOL				
PETROLEUM, ETHER				
PAINT, VARNISH				
DEGREASERS				
ACIDS, AMMONIA				
FERTILIZERS, PESTICIDES				
RADIATION OF ANY KIND				
LOUD NOISE				
LEAD, PLUMBING, STAINED GLASS				
SMOKE, OR A FIREFIGHTER				
OTHER				

NOTE: ALL EMPLOYMENT DECISIONS ARE MADE BY VOLKSWAGEN GROUP OF AMERICA (VWGoA)

All of the information I have provided herein is true, correct, and complete to the best of my knowledge. I agree that any omission, misrepresentation or falsification of information in the Personal Medical History Questionnaire will result in the withdrawal of my conditional job offer or discharge if I am employed by Volkswagen Group of America.

Signature _____

Social Security Number ____--____--____

Date _____



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

TODAY'S DATE _____

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DATE OF BIRTH: _____ PLACE OF BIRTH _____

MALE FEMALE SSN: _____ / _____ / _____ PHONE#: _____

ADDRESS: _____ CITY: _____

COUNTY: _____ STATE: _____ ZIP: _____

POSITION APPLIED FOR: _____ PRODUCTION SKILLED ADMIN

PREVIOUS EMPLOYERS -- BEGINNING WITH CURRENT OR MOST RECENT PLACE OF EMPLOYMENT:

COMPANY	JOB DESCRIPTION	DETAILS	INJURY OR ILLNESS

MEDICATION HISTORY

PLEASE LIST IN THE SPACE BELOW THE NAME OF EACH MEDICATION YOU HAVE TAKEN DURING THE PAST TWO MONTHS, AND THE CONDITION WHICH PROMPTED THE USE OF THE MEDICATION. THE LIST MUST INCLUDE NON-PRESCRIPTION MEDICATIONS SUCH AS ASPIRIN, VITAMINS, AND COLD MEDICATIONS.

WHEN DID YOU LAST RECEIVE A TETANUS SHOT? _____



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

FAMILY HISTORY:

PLEASE INDICATE BY CHECKING THE APPROPRIATE BOX IF ANY BLOOD RELATIVE (INCLUDING GRANDPARENTS, AUNTS, UNCLES, CHILDREN, ETC.) HAS EXPERIENCED/SUFFERED FROM ANY OF THE FOLLOWING:

ALCOHOL ABUSE	<input type="checkbox"/>	HAY FEVER	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>
BACK TROUBLE	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>
BLEEDING TENDENCY	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	LEUKEMIA	<input type="checkbox"/>
COLITIS	<input type="checkbox"/>	MIGRAINE	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	MENTAL ILLNESS	<input type="checkbox"/>
DRUG ABUSE	<input type="checkbox"/>	ON-THE JOB INJURY	<input type="checkbox"/>
EMPHYSEMA	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	STROKE	<input type="checkbox"/>
GOITER	<input type="checkbox"/>	SUICIDE	<input type="checkbox"/>
GOUT	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>

LIST YOUR HOBBIES, (FOR EXAMPLE: BOWLING, AUTO REPAIR, FIREFIGHTER, FITNESS, ETC.):

LIFESTYLE HISTORY:

1. HOW MANY CIGARETTES DO YOU SMOKE PER DAY? _____
2. HOW MANY PIPE BOWLS FULL OF TOBACCO DO YOU SMOKE PER DAY? _____
3. HOW MANY CIGARS DO YOU SMOKE PER DAY? _____
4. HOW MANY YEARS HAVE YOU USED TOBACCO PRODUCTS? _____
5. IF YOU HAVE STOPPED SMOKING, HOW LONG AGO DID YOU QUIT? _____

EXPLANATION: (IF YOU WOULD LIKE TO FURTHER EXPLAIN YOUR RESPONSE TO ANY OF THE ABOVE QUESTIONS, PLEASE DO SO IN THE SPACE PROVIDED BELOW.)

QUESTION NO. EXPLANATION



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

LIFESTYLE HISTORY: (continued)

DO YOU USE SMOKELESS TOBACCO (IF YES DESCRIBE TYPE)? _____

HOW MUCH LIQUOR DO YOU DRINK PER WEEK (ESTIMATE FL. OZ.)? _____

HOW MUCH BEER DO YOU DRINK PER WEEK (ESTIMATE FL. OZ.)? _____

HOW MUCH WINE DO YOU DRINK PER WEEK (ESTIMATE FL. OZ.)? _____

HOW MUCH COFFEE DO YOU DRINK PER WEEK (ESTIMATE FL. OZ.)? _____

HOW MUCH CARBONATED SOFT DRINK DO YOU DRINK PER WEEK (ESTIMATE FL. OZ.)? _____

MEDICAL HISTORY QUESTIONS

HAVE YOU EVER SUFFERED FROM ANY OF THE INJURIES LISTED BELOW AND/OR UNDERGONE CORRECTIVE MEASURES TO RECOVER FROM THE CONDITION:

PLEASE CHECK THE APPROPRIATE BOX

	<u>YES</u>		<u>NO</u>
1. BACK INJURY OR RELATED TREATMENT	<input type="checkbox"/>		<input type="checkbox"/>
2. HERNIA OR RUPTURE	<input type="checkbox"/>		<input type="checkbox"/>
3. JOB RELATED INJURY REQUIRING TIME OFF FROM WORK	<input type="checkbox"/>	HOW MANY DAYS	<input type="checkbox"/>
4. INJURY/ILLNESS REQUIRING MORE THAN 10 DAYS RECOVERY	<input type="checkbox"/>	_____	<input type="checkbox"/>
5. MENTAL CONDITION OR TREATMENT WHICH LIMITED YOUR ACTIVITY	<input type="checkbox"/>	HOW MANY DAYS	<input type="checkbox"/>
6. SURGERY	<input type="checkbox"/>	_____	<input type="checkbox"/>
		DESCRIBE BELOW	

PLEASE EXPLAIN/DESCRIBE, PROVIDE DATES, AND CIRCUMSTANCES ASSOCIATED WITH ANY YES ANSWERS:

1. _____
2. _____
3. _____
4. _____
5. _____

TYPE OF SURGERY	IN OR OUT-PATIENT	DATE OF SURGERY	HAVE YOU FULLY RECOVERED?
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Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

7. PLEASE INDICATE ANY NON-SURGICAL HOSPITAL STAY:

DATE	REASON

	<u>YES</u>	<u>NO</u>
8. PHYSICAL, MUSCULAR, OR SKELETAL CONDITION WHICH CAUSED YOU TO LIMIT YOUR ACTIVITY?	<input type="checkbox"/>	<input type="checkbox"/>
9. JOINT INJURY ON OR OFF THE JOB?	<input type="checkbox"/>	<input type="checkbox"/>
10. SHOULDER INJURY ON OR OFF THE JOB?	<input type="checkbox"/>	<input type="checkbox"/>
11. ELBOW INJURY OR TREATMENT ON OR OFF THE JOB?	<input type="checkbox"/>	<input type="checkbox"/>
12. WRIST, HAND, FINGER INJURY OR TREATMENT?	<input type="checkbox"/>	<input type="checkbox"/>
13. KNEE INJURY OR TREATMENT?	<input type="checkbox"/>	<input type="checkbox"/>
14. ANKLE/FOOT INJURY OR TREATMENT?	<input type="checkbox"/>	<input type="checkbox"/>
15. MEDICAL CONDITION OR TREATMENT THAT LIMITED YOUR ACTIVITY?	<input type="checkbox"/>	<input type="checkbox"/>
16. HAVE YOU EVER BEEN ADVISED NOT TO WORK AROUND DUST VAPORS, SOLVENTS, HYDROCARBONS, OR PAINT?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE EXPLAIN/DESCRIBE, PROVIDE DATES, AND CIRCUMSTANCES ASSOCIATED WITH ANY YES ANSWERS:



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

17. ANY SERIOUS INJURIES? (WHICH REQUIRED THREE (3) OR MORE DAYS OF HOSPITALIZATION.)

DATE	DESCRIPTION

18. ALLERGIC REACTION TO ANY MEDICINE?

PLEASE LIST ANY MEDICATIONS TO WHICH YOU HAVE HAD ALLERGIC REACTION AND THE SPECIFIC REACTION YOU EXPERIENCED:

	<u>YES</u>	<u>NO</u>
19. HAVE YOU HAD OR DO YOU HAVE A NEED FOR MEDICAL ATTENTION AS A RESULT OF EXPOSURE TO DUST, VAPOR, PAINT, FUMES, OR SOLVENTS. ?		
20. DO YOU FEEL TIRED?		
21. HAS YOUR THIRST INCREASED?		
22. HAVE YOU RECENTLY EXPERIENCED A RECENT WEIGHT GAIN OR LOSS?		
23. HAVE YOU NOTICED A CHANGE IN SKIN COLOR?		
24. DO YOU HAVE ANY SKIN RASHES OR ITCHING?		
25. DO YOU HAVE UNUSUALLY DRY SKIN?		
26. DO YOU HAVE ANY SORES OR WOUNDS THAT WILL NOT HEAL?		
27. ANY EYE PAIN OR DISCOMFRONT?		

PLEASE EXPLAIN/DESCRIBE, PROVIDE DATES, AND CIRCUMSTANCES ASSOCIATED WITH ANY YES ANSWERS:



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DO YOU OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING:

	<u>YES</u>	<u>NO</u>
28. GLAUCOMA?		
29. BLURRED VISION?		
30. HALOS AROUND LIGHTS?		
31. ANY CHANGE IN VISION?		
32. PROBLEMS TELLING RED OR GREEN COLORS?		
33. PROBLEMS TELLING YELLOW OR BLUE COLORS?		
34. ANY PROBLEMS HEARING?		
35. RINGING IN YOUR EARS?		
36. A LOT OF NASAL STUFFINESS?		
37. DRAINAGE DOWN THE BACK OF YOUR THROAT?		
38. FREQUENT OR SEVERE NOSE BLEEDS?		
39. PERSISTENT HOARSENESS?		
40. A LUMP IN YOUR THROAT?		
41. A SORE TONGUE OR MOUTH?		
42. BLEEDING GUMS?		
43. PAIN, TIGHTNESS, OR PRESSURE IN THE FRONT OR BACK OF YOUR CHEST?		
44. AN ELECTROCARDIOGRAM WITH A READING OTHER THAN NORMAL?		
45. SWELLING OF YOUR FEET OR ANKLES?		

PLEASE EXPLAIN/DESCRIBE, PROVIDE DATES, AND CIRCUMSTANCES ASSOCIATED WITH ANY YES ANSWERS:



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DO YOU OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING:

	<u>YES</u>	<u>NO</u>
46. IRREGULAR HEART BEAT?	<input type="checkbox"/>	<input type="checkbox"/>
47. CRAMPS IN CALF MUSCLES WHEN YOU WALK?	<input type="checkbox"/>	<input type="checkbox"/>
48. FINGERS OR TOES BECOME COLD, NUMB, WHITE, OR BLUISH?	<input type="checkbox"/>	<input type="checkbox"/>
49. CERTAIN FOODS UPSET YOUR STOMACH?	<input type="checkbox"/>	<input type="checkbox"/>
50. ANY TROUBLE SWALLOWING?	<input type="checkbox"/>	<input type="checkbox"/>
51. AWAKING AT NIGHT WITH THE FEELING OF FULLNESS UNDER BREAST BONE?	<input type="checkbox"/>	<input type="checkbox"/>
52. BLOOD FROM YOUR RECTUM?	<input type="checkbox"/>	<input type="checkbox"/>
53. BLACK BOWEL MOVEMENTS OR TAR LIKE STOOL?	<input type="checkbox"/>	<input type="checkbox"/>
54. ANY RECENT CHANGES IN YOUR BOWEL MOVEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>
55. FREQUENT CHANGES IN YOUR BOWEL MOVEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>
56. FREQUENT CHEST COLDS?	<input type="checkbox"/>	<input type="checkbox"/>
57. A CONSTANT OR BOTHERSOME COUGH?	<input type="checkbox"/>	<input type="checkbox"/>
58. COUGHING OF BLOOD?	<input type="checkbox"/>	<input type="checkbox"/>
59. SPUTUM OR PHLEGM BETWEEN COLDS?	<input type="checkbox"/>	<input type="checkbox"/>
60. DIFFICULTY BREATHING?	<input type="checkbox"/>	<input type="checkbox"/>
61. WHEEZING OR WHISTLING IN YOUR CHEST?	<input type="checkbox"/>	<input type="checkbox"/>
62. HARD TIME BREATHING IN WINTER?	<input type="checkbox"/>	<input type="checkbox"/>
63. BACK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE EXPLAIN/DESCRIBE, PROVIDE DATES, AND CIRCUMSTANCES ASSOCIATED WITH ANY YES ANSWERS:



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DO YOU OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING:

	<u>YES</u>	<u>NO</u>
64. PAIN IN YOUR LEGS OR FEET?	<input type="checkbox"/>	<input type="checkbox"/>
65. BACK PAIN THAT INTERFERES WITH YOUR WORK ACTIVITIES?	<input type="checkbox"/>	<input type="checkbox"/>
66. JOINT PAIN, STIFFNESS OR SWELLING?	<input type="checkbox"/>	<input type="checkbox"/>
67. TROUBLE WALKING OR USING YOUR HIP OR KNEE JOINTS?	<input type="checkbox"/>	<input type="checkbox"/>
68. FREQUENT OR SEVERE HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>
69. SPELLS, DIZZINESS, FAINTNESS, OR LIGHTHEADEDNESS?	<input type="checkbox"/>	<input type="checkbox"/>
70. DOUBLE VISION?	<input type="checkbox"/>	<input type="checkbox"/>
71. AN EPISODE WHEN YOU LOST TRACK OF WHAT HAPPENED AROUND YOU FOR SHORT PERIODS OF TIME?	<input type="checkbox"/>	<input type="checkbox"/>
72. A FAINTING SPELL, BLACK OUT, OR LOSS OF CONSCIOUSNESS?	<input type="checkbox"/>	<input type="checkbox"/>
73. CONVULSIONS, FITS, SEIZURES OR SPELLS?	<input type="checkbox"/>	<input type="checkbox"/>
74. NUMBNESS OR TINGLING IN YOUR HEAD, ARMS, HANDS OR LEGS?	<input type="checkbox"/>	<input type="checkbox"/>
75. ANEMIA?	<input type="checkbox"/>	<input type="checkbox"/>
76. ARTHRITIS?	<input type="checkbox"/>	<input type="checkbox"/>
77. ASTHMA?	<input type="checkbox"/>	<input type="checkbox"/>
78. BACK TROUBLE?	<input type="checkbox"/>	<input type="checkbox"/>
79. BROKEN BONES?	<input type="checkbox"/>	<input type="checkbox"/>
80. DIABETES?	<input type="checkbox"/>	<input type="checkbox"/>
81. GOUT?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE EXPLAIN/DESCRIBE, PROVIDE DATES, AND CIRCUMSTANCES ASSOCIATED WITH ANY YES ANSWERS:



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DO YOU OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING:

	<u>YES</u>	<u>NO</u>
82. HEART ATTACK?	<input type="checkbox"/>	<input type="checkbox"/>
83. POLIO?	<input type="checkbox"/>	<input type="checkbox"/>
84. SEIZURES/SPELLS?	<input type="checkbox"/>	<input type="checkbox"/>
85. DO YOU USE ANY TYPE OF BACK BRACE, SHOE INSERTS, OR ARCH SUPPORTS?	<input type="checkbox"/>	<input type="checkbox"/>
86. ANY PHYSICAL CONDITION WHICH SUBSTANTIALLY LIMITS YOUR MOBILITY, RANGE OF MOTION, ECT.?	<input type="checkbox"/>	<input type="checkbox"/>
87. BUNIONS, CORNS, MORTON'S NEUROMA, HEEL SPURS?	<input type="checkbox"/>	<input type="checkbox"/>
88. A PROBLEM WITH YOUR ELBOW?	<input type="checkbox"/>	<input type="checkbox"/>
89. A PROBLEM WITH YOUR SHOULDER, INCLUDING SEPARATION OR DISLOCATION?	<input type="checkbox"/>	<input type="checkbox"/>
90. "NERVE COMPRESSION" OR "DISC PROBLEMS?"	<input type="checkbox"/>	<input type="checkbox"/>
91. PROBLEMS WITH KNEES OR HIPS?	<input type="checkbox"/>	<input type="checkbox"/>
92. PROBLEMS WITH ANKLES OR HIPS?	<input type="checkbox"/>	<input type="checkbox"/>
93. PROBLEMS WITH BALANCE, EARS OR HEARING?	<input type="checkbox"/>	<input type="checkbox"/>
94. PROBLEMS WITH SKIN INCLUDING DRY SKIN, ALLERGY, RASHES, ECZEMA OR FLAKING?	<input type="checkbox"/>	<input type="checkbox"/>
95. LUNG PROBLEMS INCLUDING, WHEEZING, ASTHMA, PNEUMONIA, BRONCHITIS, OR TB?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE EXPLAIN/DESCRIBE, PROVIDE DATES, AND CIRCUMSTANCES ASSOCIATED WITH ANY YES ANSWERS:



Volkswagen Group of America (VWGoA) Personal Medical History Questionnaire

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DO YOU OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING:

	<u>YES</u>	<u>NO</u>
96. GANGLION CYST, CARPAL TUNNEL SYNDROME, THORACIC OUTLET PROBLEM?	<input type="checkbox"/>	<input type="checkbox"/>
97. TENDONITOUS OR BURSITIS?	<input type="checkbox"/>	<input type="checkbox"/>
98. DO YOU HAVE ANY MENTAL OR NERVOUS CONDITION WHICH SUBSTANTIALLY LIMITS ONE OR MORE OF YOUR LIFE ACTIVITIES?	<input type="checkbox"/>	<input type="checkbox"/>
99. A WORKER'S COMPENSATION CLAIM?	<input type="checkbox"/>	<input type="checkbox"/>
100. MOVED FROM ONE POSITION TO ANOTHER DUE TO A MEDICAL CONDITION?	<input type="checkbox"/>	<input type="checkbox"/>
101. ASSIGNED LIGHT, RESTRICTED, OR LIMITED DUTY FOR ANY REASON?	<input type="checkbox"/>	<input type="checkbox"/>
102. DO YOU HAVE A CUMULATIVE TRAUMA DISORDER?	<input type="checkbox"/>	<input type="checkbox"/>
103. DO YOU WEAR CONTACT LENSES? (RECORDS NOT REQUIRED)	<input type="checkbox"/>	<input type="checkbox"/>
104. DO YOU WEAR GLASSES? (RECORDS NOT REQUIRED)	<input type="checkbox"/>	<input type="checkbox"/>
105. DO YOU EVER HAVE A FEELING OF NUMBNESS OR TINGLING IN YOUR FINGERS?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE EXPLAIN/DESCRIBE, PROVIDE DATES, AND CIRCUMSTANCES ASSOCIATED WITH ANY YES ANSWERS:
