

PRE-PLACEMENT MEDICAL HISTORY

Name: _____ Date: _____

Employer: _____ Job Title: _____

	Yes	No	Don't Know	Details
Have you received any compensation awards, disability insurance or pension because of illness or injury?				
Have you had any surgery or hospitalization? Give dates and reasons.				
Any eye or ear conditions?				
Have you ever been told you had a heart or blood vessel disease?				
Have you or any blood relative had a heart attack?				
Have you ever had an abnormal electrocardiogram (EKG)?				
Have you had angina, thumping or racing of your heart beat?				
Have you ever had any heart murmurs?				
Do you get any regular vigorous exercise?				
Have you ever been told you had high blood pressure?				
Do you ever have shortness of breath?				
Have you ever had asthmas or any lung or chest disorder or surgery?				
Do you have any difficulty using respirators?				
Have you ever had abdominal disorders such as stomach or intestinal spasms, ulcer, colitis, diverticulitis, pancreatitis or other disorder?				
Have you had a hernia (location)?				
Are you pregnant?				
Have you had bone or joint disease, fractures, or dislocations?				
Have you had back or neck injuries, pain or other disorders?				
Have you had a skin reaction to any substances or any persisten or recurrent skin conditions?				
Have you had a seizure, convulsion, repeated fainting or dizzy spells?				
Have you had migraines, recurrent headaches, or head injuries?				
Have you had neuralgia, neuritis, nerve disorders or injury?				
Have you had a psychiatric or emotional illness or nervous disorder?				
Have you had or do you have diabetes or excessive thirst?				

History of Diseases:

Have you had any of the following:

	Yes	No	Unsure
Measles			
Typhoid Fever			
Dysentery			
Whooping Cough			
Diphtheria			

	Yes	No	Unsure
Scarlet Fever			
Tuberculosis			
Mumps			
Chicken Pox			

Immunization Records Provided:

Yes	No

I give my permission to release any and all information both written and verbal, regarding my medical conditions or files to MMH or its designee. I certify that all my responses are true to the best of my knowledge. I understand that any falsification of information may result in disciplinary action, up to and including termination of my employment with MMH.

Employee Printed Name

Employee Signature

Date

(over)

Name:	SS#:	Date of Birth:
Address:	City:	State, Zip:
Phone (home):	Phone (work):	Gender:
Employer:	Department:	Job/Title:

BRIEF PHYSICAL EXAM

VITALS

BP R Arm ____ / ____	BP L Arm ____ / ____	Pulse ____ Temp ____	Weight _____	Height ____' ____"
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Allergies:

Medications:

PATIENT MEDICAL HISTORY

Recent Treatment:

Surgeries:

Major Trauma:

Medical Condition/Diseases:

SOCIAL HISTORY

	Yes	No
Have you ever smoked (cigarettes, cigars, pipe), chewed tobacco or rubbed snuff?		
Do you now smoke, chew, or rub?		
<input type="text"/> If yes, how much per day?		
<input type="text"/> Advised to quit?		
Do you drink alcohol?		
<input type="text"/> If yes, frequency?		

PHYSICAL EXAM

General:	<input type="text"/>	Well Nourished	<input type="text"/>	Obese	<input type="text"/>	Pale	<input type="text"/>	Pink	<input type="text"/>	NAD
Lungs:	<input type="text"/>	Clear A/P	<input type="text"/>	Wheezing	<input type="text"/>	Rhonchi	<input type="text"/>		<input type="text"/>	
Respiratory:	<input type="text"/>	Easy/Unlabored	<input type="text"/>	Dyspneic	<input type="text"/>	Labored with Exertion	<input type="text"/>	Labored	<input type="text"/>	
Heart:	<input type="text"/>	Regular Rate & Rhythm	<input type="text"/>	Murmur	<input type="text"/>		<input type="text"/>		<input type="text"/>	
Abdomen:	<input type="text"/>	Soft BS X4	<input type="text"/>	Organmegaly	<input type="text"/>		<input type="text"/>		<input type="text"/>	
Spine-Flexion:	<input type="text"/>	Normal	<input type="text"/>	Abnormal	<input type="text"/>		<input type="text"/>		<input type="text"/>	
Musculoskeletal-Gait:	<input type="text"/>	Normal	<input type="text"/>	Abnormal	<input type="text"/>		<input type="text"/>		<input type="text"/>	
Inguinal Hernia (male):	<input type="text"/>	Normal	<input type="text"/>	Abnormal	<input type="text"/>		<input type="text"/>		<input type="text"/>	

COMMENTS

Name: _____

VISION

Far - Uncorrected

Both 20/____
Right 20/____
Left 20/____

Far - Corrected

Both 20/____
Right 20/____
Left 20/____

Near - Uncorrected

Both 20/____
Right 20/____
Left 20/____

Near - Corrected

Both 20/____
Right 20/____
Left 20/____

Color Vision

<input type="checkbox"/>	Basic
<input type="checkbox"/>	Normal
<input type="checkbox"/>	Abnormal

Binocular Vision

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

Corrected Used

<input type="checkbox"/>	Wears Glasses
<input type="checkbox"/>	Wears Contacts
<input type="checkbox"/>	Wears Reading Glasses

Horizontal Peripheral Vision

Right _____ (degrees - maximum 85)
Left _____ (degrees - maximum 85)

BACK REQUIREMENTS

	Yes	No
Lift Instructions Reviewed		
Lift Performed		
Back Pamphlet Given		
Flex & Extension Exam		

COMMENTS:

Signature of Medical Examiner

Date Exam Completed

Employee Latex Allergy Screening Tool

Important caution: This tool is not intended to be all-inclusive. Individuals who are uncertain whether they are or may have sensitivities to natural latex should consult their physician.

Have you ever had a reaction to latex devices? Yes No
If yes, describe the reaction and under what circumstances did it occur? _____

Have you ever been told by a doctor that you have an allergy to any latex product? Yes No
If yes, to what specifically did the doctor say you were allergic? _____

Do you have any congenital abnormalities (i.e. spina bifida, myeloma)? Yes No
Other: _____

Have you had a reaction to the following personal sources of latex?

balloons	<input type="checkbox"/> Yes	<input type="checkbox"/> No	latex birth control	<input type="checkbox"/> Yes	<input type="checkbox"/> No
rubber gloves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	dental retainer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
hot water bottles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	erasers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
rubber bands, balls	<input type="checkbox"/> Yes	<input type="checkbox"/> No	face masks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
foam pillows	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ACE bandages	<input type="checkbox"/> Yes	<input type="checkbox"/> No
baby bottle nipples	<input type="checkbox"/> Yes	<input type="checkbox"/> No	cuffs, elastic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
pacifiers, teething	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ostomy bags	<input type="checkbox"/> Yes	<input type="checkbox"/> No
belts, bras,	<input type="checkbox"/> Yes	<input type="checkbox"/> No	shoewear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	rubber grips	<input type="checkbox"/> Yes	<input type="checkbox"/> No

After handling latex products, have you experienced:

difficulty breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	redness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
chapped/"cracked"	<input type="checkbox"/> Yes	<input type="checkbox"/> No	swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
runny	<input type="checkbox"/> Yes	<input type="checkbox"/> No	hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
itching (hands, eyes)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you have a history of:

contact dermatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	autoimmune disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(i.e., lupus, etc.)		

Do you have any food allergies? Yes No

If yes, are you allergic to any of the following?

	Recent	Longstanding		Recent	Longstanding
<input type="checkbox"/> Bananas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kiwis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Avocados	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chestnuts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Peaches	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tomatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Papaya	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>			

If yes, describe your reaction _____

Have you had any previous surgeries? Yes No
How many before the age of one? _____

Have you had extensive dental work? Yes No

Employee Signature

Date

Signature Employee Health Nurse

Date

Tuberculosis Screening Consent Form

Name _____ Dept. _____

Please answer the following questions:

- | | | |
|--|------------------------------|-----------------------------|
| Have you ever had TB? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever lived with someone who had TB? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been exposed to TB in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you foreign-born? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had a reaction to a TB skin test? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been treated for a TB infection or disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever received BCG live vaccine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had a measles, flu, or other vaccination in the past 6 weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you taking corticosteroid medications (such as prednisone) or immunosuppressive drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had an organ transplant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have Sarcoidosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you a Hepatitis B carrier? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you currently pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you are HIV Positive please notify the Employee Health Director before the administration of the TB skin test.

Please explain if you answered "yes" to any of the questions above, providing dates: _____

Please provide date of last TB skin test, if known: _____

I have answered the above questions to the best of my ability. If I am advised against receiving a tuberculin skin test for medical reasons, I will provide a written statement from my physician indicating that he/she believes I am free of tuberculosis disease.

- I consent to administration of the tuberculosis skin test.
- I do not consent to TB skin testing. Please explain: _____

Signature _____ Date _____

Additional Comments: _____

**HEALTHCARE PROFESSIONAL'S WRITTEN OPINION FOR PROVIDING
HEPATITIS B VACCINE**

Name

Date

Department

Title

This job has the potential for you to be exposed to the blood/body fluid of patients.

As described in the OSHA rules and regulations on Occupational Exposure to Bloodborne Pathogens (29 CFR Part 1910.1030), the Hepatitis B vaccine shall be made available, at no cost, within 10 working days of the initial assignment to all employees who have occupational exposure to pathogenic (disease producing) micro-organisms that are present in human blood and other body fluids. These pathogens include, but are not limited to, Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV). You are entitled to a copy of this regulation and have access to the MMH Exposure Control Plan. Copies of the OSHA regulation are located in Employee Health, Staff Development, and the Medical Library. The Exposure Control Plan is available in Meditech. If you would like a copy of either one or both standards, please contact Employee Health.

Have you cared for or lived with someone with Hepatitis B in the past year? Yes No
If Yes, please explain: _____

Have you begun or completed a Hepatitis B vaccination series in the past? Yes No
If Yes, please provide dates: _____

Has antibody testing revealed that you have immunity? Yes No

Is there a medical reason you feel you should not receive the vaccine? Yes No
If Yes, please explain: _____

Employee's Signature

Date

Employee Name: _____

***HEALTHCARE PROFESSIONAL'S WRITTEN OPINION:**

The Hepatitis B Vaccine IS INDICATED for the above mentioned employee.

The Hepatitis B Vaccine IS NOT INDICATED for the above employee because:

- The employee reports previously completing the Hepatitis B series.
- Antibody testing has revealed that the employee is immune.
- The vaccine is contraindicated for medical reasons.
- The evaluating healthcare professional believes there is another significant reason.
- Not recommended for job position.
- Series completed greater than 2 months ago. Recommend HBSAB if exposure occurs.
- We do not have documentation of immunity to hepatitis B. If you are exposed to blood or body fluids, it is important that you communicate this to the doctor or healthcare provider who treats you so he/she can provide appropriate care.

Comments: _____

Healthcare Professional's Signature

Date

*Consistent with Employee/Health physician approved protocols.

Copy sent to employee:

Date: _____

Initials: _____

Employee's Name (Please Print) _____

Age _____

Department _____

HEPATITIS B VACCINE CONSENT

The Hepatitis B Vaccine series normally consists of 3 injections (initial, one & six months). I understand that it is my responsibility to report to the Employee Health Department for initial and subsequent injections. I have been provided a copy of the Centers for Disease Control's Vaccine Information Statement (VIS) and a copy of the evaluating Healthcare Professional's Written Opinion.

If I am pregnant, breast-feeding, or have known sensitivity to yeast, I will provide written consent from my physician before receiving the vaccine.

I have been given an opportunity to ask questions regarding the Hepatitis B Vaccine and the risks involved in receiving the injections. After review of the available information on the Hepatitis B Vaccine, I voluntarily elect to receive the vaccine injections and the Hepatitis B Post Testing to determine my immunity status.

Employee's Signature _____

Date of Birth _____

Date _____

	Date	Site	Dose	Lot #	VIS	Given By
1st Injection						
2nd Injection						
3rd Injection						

Hepatitis B Post Testing (HBSAB): Date: _____ Result: _____

If Hepatitis B Post Test indicates no immunity; a second series of Hepatitis B vaccine is to be given.

	Date	Site	Dose	Lot #	VIS	Given By
1st Injection						
2nd Injection						
3rd Injection						

Hepatitis B Post Testing (HBSAB): Date: _____ Result: _____

(Sign the back if you do not want or have had the Hepatitis B Vaccine)

DECLINATION

(Sign below if you do not want the Hepatitis B Vaccine)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee's Name (Please Print)

Date of Birth

Department

Employee's Signature

Date

Witness

Date

Reviewed/Revised:

Feb-88	Apr-01	Jul-02
Aug-03	Jun-04	Jan-05
Dec-05	Jun-07	Feb-09
Feb-10	Jun-10	