MEDICAL HISTORY QUESTIONNAIRE

This questionnaire is for the purpose of obtaining a complete health profile and to comply with the Americans with Disabilities Act. Further, the information will allow your employer to evaluate and provide reasonable accommodation for any qualifying disability you may have. This information will be kept confidential in a separate medical file, apart from your personnel file.

IMPORTANT: Any employee who falsely represents his/her condition in writing at the time of entering into the employment relationship with the employer may be denied Workers' Compensation benefits. In addition, any false representation at this time may subject the employee to termination.

NAME: _____ **SSN:** _____

ADDRESS: _____ **CITY/ZIP** _____

TELEPHONE: _____ **DOB:** _____ **POSITION/DEPT.** _____

EMERGENCY CONTACT: (NAME) _____ **TELEPHONE:** _____ **RELATIONSHIP** _____

HEIGHT	WEIGHT	BLOOD PRESSURE	TEMP.	PULSE	RESP.

UNCORRECTED		CORRECTED		ISHIHARA
® 20/	Ⓛ 20/	® 20/	Ⓛ 20/	

INSTRUCTIONS: Circle Y for YES or N for NO to the following questions and give dates for any yes answers. Do not skip any questions.

Have you ever had or been treated for any of the following conditions or diseases?

			Date
1.	Severe Headaches	☐ Y ☐ N	_____
2.	Dizziness or fainting spells	☐ Y ☐ N	_____
3.	Seizures	☐ Y ☐ N	_____
4.	Epilepsy	☐ Y ☐ N	_____
5.	Anemia, hemophilia or other blood disorder	☐ Y ☐ N	_____
6.	Rheumatic fever	☐ Y ☐ N	_____
7.	Diabetes	☐ Y ☐ N	_____
8.	Hypoglycemia (low blood sugar)	☐ Y ☐ N	_____
9.	Cardiac disease	☐ Y ☐ N	_____
10.	High blood pressure	☐ Y ☐ N	_____
11.	Varicose vein or leg ulcer	☐ Y ☐ N	_____
12.	Thrombophlebitis (inflammation of vein or blood clot)	☐ Y ☐ N	_____
13.	Thyroid	☐ Y ☐ N	_____
14.	Hay fever/asthma/respiratory disorder	☐ Y ☐ N	_____
15.	Chronic cough	☐ Y ☐ N	_____
16.	Shortness of breath	☐ Y ☐ N	_____
17.	Chest pain	☐ Y ☐ N	_____
18.	Bloody sputum	☐ Y ☐ N	_____
19.	Total deafness/hearing loss/ear problems	☐ Y ☐ N	_____
20.	Mental Retardation/Learning Disability	☐ Y ☐ N	_____
21.	Eye/vision conditions (glasses, contacts, color blindness, etc.)	☐ Y ☐ N	_____
22.	Hernia (rupture)	☐ Y ☐ N	_____
23.	Ulcers	☐ Y ☐ N	_____
24.	Kidney or bladder trouble	☐ Y ☐ N	_____
25.	Hepatitis/Liver disease	☐ Y ☐ N	_____
26.	Parkinson's Disease	☐ Y ☐ N	_____
27.	Skin Trouble	☐ Y ☐ N	_____
28.	Positive PPD (TB skin test)	☐ Y ☐ N	_____
29.	Tuberculosis	☐ Y ☐ N	_____
30.	Increased fatigue, night sweats	☐ Y ☐ N	_____

			Date
31.	Alcoholism/drug addiction	☐ Y ☐ N	_____
32.	Nervous breakdown, mental illness, psychiatric treatment	☐ Y ☐ N	_____
33.	Arthritis, rheumatism	☐ Y ☐ N	_____
34.	Backache	☐ Y ☐ N	_____
35.	Head injury	☐ Y ☐ N	_____
36.	Neck or back injury	☐ Y ☐ N	_____
37.	Leg/knee/hip/ankle injury	☐ Y ☐ N	_____
38.	Elbow/shoulder/wrist/arm/hand injury	☐ Y ☐ N	_____
39.	Repetitive strain	☐ Y ☐ N	_____
40.	Arthroscopy of a joint	☐ Y ☐ N	_____
41.	Herniated (slipped) disc	☐ Y ☐ N	_____
42.	Surgical removal of disc or fusion	☐ Y ☐ N	_____
43.	Knee surgery	☐ Y ☐ N	_____
44.	Any fracture or broken bone	☐ Y ☐ N	_____
45.	Any other orthopedic surgery	☐ Y ☐ N	_____
46.	Amputation of body part	☐ Y ☐ N	_____
47.	Chronic osteomyelitis (bone infection)	☐ Y ☐ N	_____
48.	Osteoporosis	☐ Y ☐ N	_____
49.	Residual disability from polio	☐ Y ☐ N	_____
50.	Muscular Dystrophy	☐ Y ☐ N	_____
51.	Cerebral Palsy	☐ Y ☐ N	_____
52.	Multiple Sclerosis	☐ Y ☐ N	_____
53.	Ankylosing Spondylitis	☐ Y ☐ N	_____
54.	Have you ever had chiropractic treatment(s)	☐ Y ☐ N	_____
55.	Complications from pregnancy	☐ Y ☐ N	_____
56.	Disorders of immune system (answer is optional)	☐ Y ☐ N	_____
57.	Are there any questions above that you do not understand?	☐ Y ☐ N	

If so, which number(s)? _____

DO NOT WRITE BELOW THIS LINE – PLEASE REVIEW CAREFULLY TO BE CERTAIN THAT ALL QUESTIONS HAVE A RESPONSE. (TURN PAGE TO CONTINUE)

Reviewer Comments: _____

MEDICAL HISTORY QUESTIONNAIRE

INSTRUCTIONS: Circle Y for YES or N for NO to the following questions and give dates for any yes answers. Do not skip any questions. Explain "YES" answers.

2.1 Please list any condition or diseases for which you have been treated in the past 5 years. _____

2.2 Have you ever been hospitalized? N Y If so, for what? _____

2.3 Have you ever had a major illness/injury in the past 5 years? N Y _____

2.4 Have you had a CT Scan or MRI? N Y _____

2.5 Have you ever filed an occurrence/accident/injury report with a previous employer? N Y _____

2.6 Have you ever had an injury, operation, disease or any disability not covered by the previous questions (sports, recreational, MVA, liability)? N Y _____

2.7 Have you ever had or been treated for a Blood and Body Fluid Exposure (i.e. needlestick, splash, etc.)? N Y _____

2.8 Have you ever filed for Workers' Compensation insurance, or received money in the form of lost wages/lump sum settlement as a result of a Workers' Compensation claim? N Y _____

2.9 Have you ever received any disability payments or settlements for inability to work? (Such as auto accidents, etc.) N Y _____

2.10 Any permanent physical condition which received an impairment rating? N Y _____

2.11 Is there any health-related reason you may not be able to perform the job which you have been offered? N Y _____

2.12 Do you have any physical limitations which prevent you from performing certain kinds of work? N Y If yes, please describe such specific work limitations/restrictions. _____

2.13 Do you require any accommodations according to your job description? N Y _____

PLEASE DO NOT WRITE BELOW THIS LINE. (TURN PAGE TO CONTINUE)

Reviewer Comments: _____

MEDICAL HISTORY QUESTIONNAIRE

Please continue answering medical history questions:

3.1 Medication Allergies / Sensitivity? If yes, explain reaction. _____

_____

3.2 Other allergies or sensitivities: _____

Latex? _____

3.3 Please list all Prescription medications or Over The Counter drugs that you take on a regular basis: _____

_____

_____

3.4 Have you ever worked around or been exposed to any of the following:

Chemotherapy N Y _____ Radiation N Y _____ Hazardous Chemical N Y _____ Laser N Y _____

When or where? _____

3.5 Do you smoke/chew tobacco? N Y If yes, how much? Packs per week _____ Number of years _____

_____

HEPATITIS B SCREEN **If, in your position, you have the potential for exposure to Blood Borne Pathogens/Blood and Body Fluids, you must complete one of the following options:**

ACCEPTANCE

I have reviewed information on the Hepatitis B Vaccination Program and I choose to:

☐ **Request Series**

I understand that it is my responsibility to contact Employee Health at Extension _____ to schedule an appointment and to receive the vaccine. The appointment is to be scheduled during the week of general employment.

Signature _____ Date _____

DECLINATION

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 for acquiring Hepatitis B, a serious disease.

If, in the future, I continue to have other occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

☐ **Decline Series**
☐ **Decline Series, Previously completed**

Signature _____ Date _____

ALL STATEMENTS AND INFORMATION GIVEN IN THIS HISTORY ARE TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. THESE QUESTIONS WERE NOT ASKED OF ME UNTIL AFTER I WAS OFFERED A JOB.

I understand that my employment is contingent upon the approval of this Medical History Questionnaire. I authorize Company Care to disclose all relevant medical information to my employer regarding my medical history and screening questionnaire.

Name (printed) _____

Signature _____ Date _____

PLEASE DO NOT WRITE BELOW THIS LINE.

Reviewer Comments: _____

_____

_____

_____

_____

Reviewer Signature _____ **Date** _____

COMPANY CARE
Occupational Health Services
A department of Lake City Medical Center

TB SCREENING AND TESTING

Name (Print) : _____ **Date of Birth:** _____

Employer/Position/Dept: _____ **Phone:** _____

Tuberculosis (TB) Screening

1. Are you being treated with immunosuppressive therapy (such as prednisone or anti-cancer drugs), or are you known to be immunocompromised? **NO** **YES-explain** _____
2. Have you ever had a positive TB skin test? **NO** **YES-what year?** _____
3. Have you ever been vaccinated with BCG? **NO** **YES**
   (Foreign country vaccine to help prevent TB.)
4. Are you pregnant? **NO** **YES, need note from your doctor to be tested or deferred**
5. Are you experiencing any of the following? :

No	Yes		If yes, explain
		Persistent Cough (> 3 weeks)	
		Weight Loss w/o Dieting	
		Persistent Low Grade Fever	
		Fatigue	
		Loss of Appetite	
		Coughing Up Blood	
		Night Sweats	
		Chest Pain	
		Exposure to known TB + person(s)	

_____ _____
SIGNATURE DATE

Date Mantoux test given: _____ Lot # _____ Expires: _____

PPD #1: Forearm _____Left _____ Right Administered by: _____

Date read: _____ Result _____ (result in mm) Signature of Reader: _____

Date Mantoux test given: _____ Lot # _____ Expires: _____

PPD #2: Forearm _____Left _____ Right Administered by: _____

Date read: _____ Result _____ (result in mm) Signature of Reader: _____

COMPANY CARE
Occupational Health Services

A Department of Lake City Medical Center
2970 W US HWY 90, ST 120
Lake City, FL 32055
P: 386-755-9675
F: 386-755-8770

Respirator Medical Evaluation Questionnaire
N-95 Fit Testing Only

Name:_____		Age: _____	Sex: ☐ Male ☐ Female
Height:_____	Weight: _____	Job Title: _____	
Unit:_____		Phone Number: _____	

This form will be kept in your employee health file. If you have any questions, please contact the Company Care Occupational Health nurse at the above phone number.

1. **Are you allergic to saccharin?** ☐ YES ☐ NO
2. **Do you currently smoke, or have you smoked tobacco in the last month?** ☐ YES ☐ NO
3. **Have you ever had any of the following conditions?**

Seizures	☐ YES ☐ NO	Claustrophobia	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Trouble smelling odors	☐ YES ☐ NO
Allergic reactions that interfere with your breathing	☐ YES ☐ NO		

4. **Have you ever had any of the following ling or pulmonary problems?**

Asbestosis	☐ YES ☐ NO	Silicosis	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Pneumothorax	☐ YES ☐ NO
Chronic bronchitis	☐ YES ☐ NO	Lung Cancer	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Broken Ribs	☐ YES ☐ NO
Pheumonia	☐ YES ☐ NO	Chest Injury or surgery	☐ YES ☐ NO
Tuberculosis	☐ YES ☐ NO		
Any other lung problems you have been told about:			☐ YES ☐ NO

5. **Do you currently have any of the following symptoms of pulmonary or lung illness?**

Shortness of breath when walking fast on level ground or walking up a slight hill or incline.	☐ YES ☐ NO	Shortness of breath.	☐ YES ☐ NO
Shortness of breath when walking with other people at an ordinart pace on level ground.	☐ YES ☐ NO	Shortness of breath that interferes with your job.	☐ YES ☐ NO
Have to stop for breath when walking at your own pace on level ground.	☐ YES ☐ NO	Cough that produces thick sputum.	☐ YES ☐ NO
Shortness of breath when washing or dressing yourself.	☐ YES ☐ NO	Coughing that occurs mostly when you are lying down.	☐ YES ☐ NO
Coughing that wakes you in the early morning.	☐ YES ☐ NO	Wheezing	☐ YES ☐ NO
Coughing up blood in the last month.	☐ YES ☐ NO	Chest pain when you breathe deeply.	☐ YES ☐ NO
Wheezing that interferes with your job.	☐ YES ☐ NO		
Any other lung problems that you have been told about			☐ YES ☐ NO

6. Have you ever had any of the following cardiovascular or heart problems?

Heart Attack	☐ YES ☐ NO	Heart Failure	☐ YES ☐ NO
Stroke	☐ YES ☐ NO	Irregular heartbeat/arrhythmia	☐ YES ☐ NO
Angina	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO
Frequent pain or chest tightness	☐ YES ☐ NO	Heartburn or indigestion not related to eating	☐ YES ☐ NO
Swelling in your legs or feet (not caused by walking)			☐ YES ☐ NO
Pain or tightness in your chest during physical activity			☐ YES ☐ NO
Pair or tightness in your chest that interferes with your job			☐ YES ☐ NO
In the past two years, have you noticed your heart skipping or missing beats			☐ YES ☐ NO
Any other symptoms that might be related to heart or circulation problems			☐ YES ☐ NO
Any other heart problems that you have been told about			☐ YES ☐ NO

7. Do you currently take medication for any of the following problems?

Breathing or lung problems	☐ YES ☐ NO	Heart trouble	☐ YES ☐ NO
Blood pressure	☐ YES ☐ NO	Seizures	☐ YES ☐ NO

8. If you have used a respirator, have you ever had any of the following problems?

Eye irritation	☐ YES ☐ NO	General weakness or fatigue	☐ YES ☐ NO
Skin allergies or rashes	☐ YES ☐ NO	Anxiety	☐ YES ☐ NO
Any other problems that interfere with your use of a respirator			☐ YES ☐ NO

Would you like to talk to the health care professional who will review this questionnaire about your answers to this quesionnaire?	☐ YES ☐ NO

NOTES: _____

_____

_____

_____

Saccharin Taste Test: ☐ **10 Sprays** ☐ **20 Sprays** ☐ **30 Sprays**

Fit Test Results

☐ **Approved for use of the following N-95 mask:**

☐ **Technol Small** ☐ **Technol Regular** ☐ **3M Small** ☐ **3M Regular**

☐ **Approved with restrictions:** _____

☐ **Denied**

☐ **able to taste saccharin** ☐ **Other:** _____

Reviewer Signature/Title: _____ **Date:** _____

Revised 4/12