EMPLOYEE HEALTH:
PRE-EMPLOYMENT/VOLUNTEER HEALTH REVIEW

Stormont Vail Health

LAST NAME FIRST NAME MI	BIRTH DATE	AGE	F M SEX	ORIENTATION DATE	TODAY'S DATE
POSITION/TITLE	**DEPARTMENT**			EMPLOYEE ID#. *(to be provided by Employee Relations)*	
ADDRESS (STREET/P.O. BOX)	**CITY, STATE, ZIP**			HOME # CELL #	

YOUR HEALTH HISTORY

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
1. FREQUENT/SEVERE HEADACHE			21. PALPITATION/POUNDING HEART			41. PAIN IN SHOULDER/ARM/HAND		
2. HEAD INJURY/CONCUSSION			22. HIGH BLOOD PRESSURE			42. CARPAL TUNNEL SYNDROME		
3. NECK INJURY/WHIPLASH			23. HEART FAILURE			43. TENDONITIS/BURSITIS		
4. RECURRENT NECK PAIN			24. KIDNEY STONE/BLOOD IN URINE			44. OVERUSE SYNDROMES		
5. DIZZINESS OR VERTIGO			25. SUGAR/ALBUMIN IN URINE			45. NUMBNESS OR WEAKNESS		
6. EPILEPSY/SEIZURES			26. DIABETES			46. PAIN IN HIP/KNEE/ANKLE/FOOT		
7. SLEEP DISORDER/PROBLEMS			27. LIVER DISEASE/JAUNDICE			47. HIP PROBLEMS		
8. VISUAL PROBLEMS			28. CHANGE IN BOWEL HABITS			48. KNEE PROBLEMS		
9. COLOR BLINDNESS			29. RECENT GAIN/LOSS OF WEIGHT			49. FOOT TROUBLE		
10. DOUBLE VISION OR BLINDNESS			30. ULCERS			50. SKIN TROUBLE, RASH OR DISEASE		
11. DO YOU WEAR GLASSES?			31. ANEMIA			51. SKIN DISORDERS		
12. DO YOU WEAR CONTACT LENSES?			32. HERNIA			52. DRAINING SORES OR WOUNDS		
13. DIFFICULTY HEARING			33. BACK PROBLEMS			53. ALLERGY TO LATEX OR RUBBER		
14. HEARING LOSS/HEARING AID			34. BACK STRAIN OR INJURY			54. RHEUMATIC FEVER		
15. RINGING IN EARS			35. BULGING/HERNIATED DISKS			55. SCARLET FEVER		
16. RECURRENT EAR INFECTIONS			36. SCIATICA/PINCHED NERVE			56. MEASLES		
17. SHORTNESS OF BREATH			37. BACK X-RAYS/MRI			57. MUMPS		
18. RECURRENT COUGH			38. BROKEN BONE OR BONE DISEASE			58. RUBELLA		
19. HEAT OR SUN STROKE			39. BONES OR JOINT DEFORMITY			59. CHICKEN POX		
20. CHEST PAIN OR PRESSURE			40. RHEUMATISM/ARTHRITIS			60. SHINGLES		

LIST OTHER CHRONIC ILLNESS OR INJURY:

COMMENTS FOR ABOVE "YES" RESPONSES: *(indicate the number with the comment)*:

ARE YOU TAKING MEDICATIONS? ☐ Yes ☐ No
If yes, list:

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No
If yes, list:

SURGICAL HISTORY

Please provide surgical information that is related to any of the above health history.

LIST PREVIOUS SURGICAL PROCEDURES (TYPE)	Year	Name and Location of Surgeon and Hospital	Complications, if any

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TUBERCULOSIS HISTORY

1. Have you ever had a **positive** tuberculin skin test (TB skin test, TST or Interferon Gamma Release Assay (IGRA blood test)? If "yes," please provide positive test result date and documentation. Also, if "yes" was preventative therapy (medication) completed? ☐ Yes ☐ No	YES	NO
2. Have you been exposed to a person with known **active** TB in the past year? *(An exposure occurs when respiratory protection is <u>not</u> <u>worn</u>.)*	YES	NO
3. As a child, did you receive the Bacille Calmette-Guérin (BCG) vaccine? If yes, your country of birth: _____ *(BCG vaccine is not generally recommended or administered in the United States.)*	YES	NO
4. In the past year, have you traveled to any foreign area with a high incidence of TB [Africa, Asia, Eastern Europe, Latin America (Mexico), or Russia]? If yes, and the trip was not for ☐ pleasure and was for ☐ volunteer, mission or other health care assistance, please answer: 1) How long was the trip _____; 2) and when did you return _____?	YES	NO
5. Do you currently have a persistent cough (3 weeks or more), coughing-up blood, recent fever, night sweats, or loss of appetite? If yes, please explain:	YES	NO
6. Do you currently or within the last year live with someone with the above symptoms? If yes, please explain:	YES	NO

OCCUPATIONAL EXPOSURE HISTORY

Have you ever had an occupational exposure (blood or body fluid, asbestos, solvents and other chemicals)? ☐ Yes ☐ No

In the past 2 weeks, any exposures to a contagious disease, measles, chicken pox, mumps etc? ☐ Yes ☐ No

TYPE OF EXPOSURE	YEAR	DETAILS

RESTRICTION or LIMITATION HISTORY

PLEASE ANSWER EACH QUESTION	YES	NO
1. Do you have any current restrictions or limitations? If yes, what are the restrictions or limitations? _____		
2. Have you ever had any serious injuries? If yes, for what injury? _____		
3. Have you ever been told that you have a permanent impairment or restriction? If yes, explain: _____		

COMMENTS

I hereby certify that the information I have furnished on this form and to the Employee Health Nurse is true and correct. I understand that falsification or omission may result in denial of or dismissal from employment/volunteer work. I authorize the Employee Health Nurse to disclose any pertinent finding(s) on a need to know basis to authorized individuals for use in regard to my employment.

I understand, I am to provide immunization and/or immunity titer testing documentation to the Stormont Vail Employee Health Nurse at my pre-employment/volunteer health screen appointment. Immunization and titer documentation includes, but is not limited to: previously completed tuberculosis testing (TB skin test or Interferon Gamma Release Assay), hepatitis B vaccinations and titer, tetanus (Td/Tdap), measles/mumps/rubella (MMR), and varicella (chicken pox vaccine or history of the disease).

I also understand, at my pre-employment/volunteer health screen I will have a sample of my blood drawn to test for Latent Tuberculosis Infection (LTBI) as well as MMR, varicella and hepatitis B titers, as applicable. Based on the health review results, I may be required to have follow-up appointments.

_____ _____

Employee Candidate Signature / Volunteer Signature *OR Parent/Guardian Signature (if volunteer is under 18)* Date