



Partners in health care ventures

EMPLOYEE OCCUPATIONAL HEALTH SERVICES

HEALTH HISTORY (The following information is requested to determine your current health status.) Please Print or Type.

Name (Last, First, Middle Initial)	Sex	Age	Birthdate	Social Security No.	Date Form Completed
Address (Street, City, State, Zip)			Home Phone	Cell Phone	Pager
Name/Phone No. of Person to Notify in Case of Emergency			Name of Personal Physician/Address		

Please Check If You Have Been Immunized For:

- Mumps  Polio  Varicella
- Rubella (German Measles)  Rubeola (Red Measles) List Year \_\_\_\_\_
- Diphtheria  Tetanus (List Year) \_\_\_\_\_
- Hepatitis B Series (List Dates: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_)

Please Check If You Have Ever Had:

- Chicken Pox/Shingles  Polio  Scarlet Fever  Rubella (German Measles)
- Hepatitis Type: \_\_\_\_\_  Rubeola (Red Measles)  Rheumatic Fever  Malaria
- Mumps  AIDS/HIV  TB (Tuberculosis)

Do You Have Any Allergies to Drugs, Dust, Pollen, Grasses, Eggs, Feathers, Foods, etc.?

Yes  No List: \_\_\_\_\_

**Smoking:** Current  Yes  No \_\_\_\_\_ pack/day \_\_\_\_\_ years

Past  Yes  No \_\_\_\_\_ pack/day \_\_\_\_\_ years

Please List Medications You Are Currently Taking (Include Vitamins, Birth Control Pills):

Name	Dosage	When Did You Start Medication

PERSONAL HISTORY SURGERY: Exclude Uncomplicated Pregnancies

YEAR	PLACE	ILLNESS/OPERATION	DOCTOR

MAJOR ILLNESS/INJURIES (Include if you have ever had broken bones, burns)		Outcome:
YEAR	ILLNESS	



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DO YOU HAVE OR HAVE YOU HAD, ANY OF THE FOLLOWING? (CIRCLE ANSWER)

Eye, Ears, Nose & Throat

Ear, Nose, Throat Problem Yes No
Eye/Vision Trouble Yes No
Cold (More than 3 year) Yes No
Hay Fever/Asthma Yes No
Ringing in Ears Yes No
Vertigo Yes No
Goiter/Thyroid Problem Yes No

Miscellaneous

Anemia Yes No
Cancer-Cyst, Tumor Growth Yes No
Chills, Fever, Night Sweats Yes No
Fatigue, Weakness Yes No
Recent Wt. Gain or Loss +/- 10 lb.) Yes No
Skin Rash/Hives Yes No
Sickle Cell Trait/Disease Yes No
High Fat (Cholesterol) in Blood Yes No
Dental Disease Yes No
Chronic Infection Yes No

Cardio-Vascular/Respiratory

Coughing/Vomiting Blood Yes No
Chronic Cough Yes No
Heart Trouble/Murmur Yes No
High Blood Pressure Yes No
Palpitating Heart Yes No
Rheumatic Fever Yes No
Shortness of Breath Yes No
Asthma Yes No
Swelling of Ankles Yes No
Lung Disease Yes No
Varicose Veins Yes No
Blood Clots in Veins Yes No
Stroke Yes No
Recent EKG Yes No
TB or Exposure Yes No
Wheezing Yes No
Coughing Up Blood Yes No
Chest Pain Yes No

Gastrointestinal

Blood in Stools Yes No
Chronic Constipation Yes No
Chronic Diarrhea Yes No
Frequent Indigestion/Heartburn Yes No
Gall Bladder Trouble Yes No
Hernia or Rupture Yes No
Stomach Trouble/Ulcer Yes No
Diabetes Yes No
Change in Appetite Yes No
Yellow Jaundice/Liver Disease Yes No
Hemorrhoids Yes No
Bloody or Tarry Stools Yes No

Neurologic/Emotional/Mental Health

Migraine Headaches Yes No
Fainting Yes No
Nervous Disorder Yes No
Depression/Tension Yes No
Convulsions/Seizures Yes No
Head Injury Yes No
Alcohol/Drug Treatment Program Yes No
Memory Disorder Yes No
Weakness/Paralysis Yes No
Numbness/Tingling Yes No

Genito-Urinary

Frequent/Painful Urination Yes No
Prostate Trouble Yes No
Kidney Trouble/Blood Urine Yes No
Sugar/Protein in Urine Yes No
Bladder Infection Yes No
Kidney Stone Yes No

For Women Only

Breast Problems/Tumors in uterus/infection of uterus/tubes or ovary problems? Yes No
Are menstrual periods regular? Yes No
Post-Menopausal? Yes No
Last Menstruation Period: Last Breast, Pap/Pelvic Exam:
Number of pregnancies, miscarriages, complications, if any.
Give dates and occurrences. Yes No

Date

Musculoskeletal

Neck/Back Injury Yes No
Neck/Back Pain Yes No
Neck/Back Surgery Yes No
Joint Pain/Swelling Yes No
Rheumatism/Arthritis Yes No
Fractures/Bone Injury Yes No
Shoulder/Elbow/Wrist/Hand Problem Yes No
Other Upper Extremity Problem Yes No
Hip/Knee/Feet Problem Yes No
Other Lower Extremity Problem Yes No

If you answered Yes to any of these, please give a brief explanation.

Multiple horizontal lines for providing a brief explanation of 'Yes' answers.

**WORK HISTORY**

What was your occupation prior to this job? \_\_\_\_\_

Describe any part of your past job that you feel may be hazardous to your health? \_\_\_\_\_

Did you wear protective equipment on this job? If Yes, specify: \_\_\_\_\_

In that job, were you exposed to any of the following?

Fumes/Dust	Yes	No	Vapors	Yes	No	Heavy Lifting	Yes	No	Emotional Stress	Yes	No
Metals	Yes	No	Heat/Cold	Yes	No	Gases	Yes	No	Chemicals	Yes	No
Solvents	Yes	No	Noise	Yes	No	Radiation	Yes	No			

Have you ever transferred from/or left a job because of:

If Yes, give brief description.

Sensitivity to chemicals, dust, sunlight, etc.	Yes	No	_____
Inability to perform certain motions.	Yes	No	_____
Inability to assume certain positions.	Yes	No	_____
Other medical reasons.	Yes	No	_____
Applied for, or received Worker's Compensation.	Yes	No	_____
Any time lost from work for past 2 years due to illness or injury.	Yes	No	_____

**SUPPLEMENTAL - PERSONAL HISTORY**

Date

Any brace or support worn?	Yes	No	_____
Have you ever lived or travelled outside the Continental U.S.A.?	Yes	No	_____
Do you have hobbies that expose you to chemicals/metals?	Yes	No	_____
Any history of a positive T.B. skin test?	Yes	No	_____
Give date of last chest x-ray. Any history of abnormal findings?	Yes	No	_____
Have you ever had any special studies such as x-ray pictures, heart studies, or special blood examinations?	Yes	No	_____

**I HEREBY CERTIFY THAT:**

- I have carefully read and completed the foregoing information in the Health Questionnaire and that my answers and explanations are true, to the best of my knowledge and belief. I understand that an omission or falsification of any of the information I have provided herein will be cause for discharge.
- I understand that this and other medical information will be held in strict confidence. It will be released only where required by law. Non-confidential information regarding work restrictions relating to job assignment will be provided to management and personnel.
- I consent to the physical assessment by the Community Health Network and it's agents.
- I understand that the purpose of the examination is for my placement and employment and that Community Health Network has no obligation to treat or diagnose existing conditions.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICAL CLEARANCE FOR N95 RESPIRATORS

**Print Name:** \_\_\_\_\_ **Employee ID#:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_  
**Age** \_\_\_\_\_ **Sex:** Male \_\_\_ Female \_\_\_ **Height:** Feet \_\_\_\_\_ Inches \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_  
**Phone# Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

1. Has your employer told you how to contact the health-care professional who will review this questionnaire? \_\_\_ Yes \_\_\_ No
2. You acknowledge this test is only for an N95 type respirator \_\_\_ Yes \_\_\_ No
3. Have you worn a respirator? \_\_\_ Yes \_\_\_ No  
If "yes" what types? \_\_\_\_\_

Yes No

5. Have you ever had any of the following cardiovascular or heart problems?  
 \_\_\_ \_\_\_ a. Heart attack  
 \_\_\_ \_\_\_ b. Stroke  
 \_\_\_ \_\_\_ c. Angina  
 \_\_\_ \_\_\_ d. Heart Failure  
 \_\_\_ \_\_\_ e. Swelling in your legs or feet (not caused by walking)  
 \_\_\_ \_\_\_ f. Heart arrhythmia (heart beating irregularly)  
 \_\_\_ \_\_\_ g. High blood pressure  
 \_\_\_ \_\_\_ h. Any other heart problem that you have been told about

### Questionnaire for Users of N95 Respirators

Yes No

1. Do you currently or have you smoked tobacco during the previous month? If "yes"  
 \_\_\_ \_\_\_ a. At what age did you start smoking? \_\_\_\_\_  
 \_\_\_ \_\_\_ b. How long ago did you quit smoking? \_\_\_\_\_  
 \_\_\_ \_\_\_ c. How many packs per day did or do you smoke? \_\_\_\_\_

6. Have you ever had any of the following cardiovascular or heart symptoms?  
 \_\_\_ \_\_\_ a. Frequent pain or tightness in your chest  
 \_\_\_ \_\_\_ b. Pain or tightness in your chest during physical activity  
 \_\_\_ \_\_\_ c. Pain or tightness in your chest that interferes with your job  
 \_\_\_ \_\_\_ d. In the previous 2 years, have you noticed your heart skipping or missing a beat?  
 \_\_\_ \_\_\_ e. Heartburn or indigestion that is not related to eating  
 \_\_\_ \_\_\_ f. Any other symptoms that you think might be related to heart or circulation problems

2. Have you ever had any of the following conditions?  
 \_\_\_ \_\_\_ a. Seizures (fits)  
 \_\_\_ \_\_\_ b. Diabetes (sugar disease)  
 \_\_\_ \_\_\_ c. Allergic reactions that interfere with your breathing  
 \_\_\_ \_\_\_ d. Claustrophobia (fear of closed-in places)  
 \_\_\_ \_\_\_ e. Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems?  
 \_\_\_ \_\_\_ a. Asbestosis  
 \_\_\_ \_\_\_ b. Asthma  
 \_\_\_ \_\_\_ c. Chronic bronchitis  
 \_\_\_ \_\_\_ d. Emphysema  
 \_\_\_ \_\_\_ e. Pneumonia  
 \_\_\_ \_\_\_ f. Tuberculosis  
 \_\_\_ \_\_\_ g. Silicosis  
 \_\_\_ \_\_\_ h. Pneumothorax (collapsed lung)  
 \_\_\_ \_\_\_ i. Lung cancer  
 \_\_\_ \_\_\_ j. Broken ribs  
 \_\_\_ \_\_\_ k. Any chest injuries or surgeries  
 \_\_\_ \_\_\_ l. Any other lung problems that you have been told about

7. Do you currently take medication for any of the following problems?  
 \_\_\_ \_\_\_ a. Breathing or lung problems  
 \_\_\_ \_\_\_ b. Heart trouble  
 \_\_\_ \_\_\_ c. Blood pressure  
 \_\_\_ \_\_\_ d. Seizures (fits)

4. Do you currently have any of the following symptoms of pulmonary or lung illness?  
 \_\_\_ \_\_\_ a. Shortness of breath  
 \_\_\_ \_\_\_ b. Shortness of breath when walking quickly on level ground or walking up a slight hill or incline  
 \_\_\_ \_\_\_ c. Shortness of breath when walking with other people at an ordinary pace or level ground  
 \_\_\_ \_\_\_ d. Have to stop for breath when walking at your own pace on level ground  
 \_\_\_ \_\_\_ e. Shortness of breath when washing or dressing yourself  
 \_\_\_ \_\_\_ f. Shortness of breath that interferes with your job  
 \_\_\_ \_\_\_ g. Coughing that produces phlegm (thick sputum)  
 \_\_\_ \_\_\_ h. Coughing that wakes you early in the morning  
 \_\_\_ \_\_\_ i. Coughing that occurs primarily when you are lying down  
 \_\_\_ \_\_\_ j. Coughing up blood in the last month  
 \_\_\_ \_\_\_ k. Wheezing  
 \_\_\_ \_\_\_ l. Wheezing that interferes with your job  
 \_\_\_ \_\_\_ m. Chest pain when you breathe deeply  
 \_\_\_ \_\_\_ n. Any other symptoms that you think might be related to lung problems

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check here \_\_\_ and go to question 9.)  
 \_\_\_ \_\_\_ a. Eye irritation  
 \_\_\_ \_\_\_ b. Skin allergies or rashes  
 \_\_\_ \_\_\_ c. Anxiety  
 \_\_\_ \_\_\_ d. General weakness or fatigue  
 \_\_\_ \_\_\_ e. Any other problem that interferes with your use of a respirator

9. Are you currently taking any medications? If yes, list here \_\_\_\_\_  
 \_\_\_\_\_

10. Would you like to talk with the health-care professional who will review this questionnaire about your answers to this questionnaire?

Please explain "yes" answers (use back of form if necessary)

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_ **Medically approved** \_\_\_ **Needs further evaluation**

Employee Health Representative: \_\_\_\_\_

MMWR: December 30, 2005