University of Miami
Environmental Health and Safety
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 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.

LAST NAME _____ FIRST NAME _____ S.S. # _____

ADDRESS _____ CITY/ZIP _____

TELEPHONE _(_____)_____-_____ Date of Birth _____/_____/_____ POSITION _____

DEPARTMENT _____ SUPERVISOR _____ BUILDING _____ ROOM#: _____

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

INSTRUCTIONS: Circle "Y" for YES and "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					Date
1.	Severe Headaches	N	Y		31	Alcoholism/Drug Addiction	N	Y	
2.	Dizziness or fainting spells	N	Y		32	Nervous Breakdown, Mental Illness, Psychiatric treatment or counseling	N	Y	
3.	Seizures	N	Y		33	Arthritis/Rheumatism	N	Y	
4.	Epilepsy	N	Y		34	Backaches	N	Y	
5.	Anemia/Hemophilia/Other Blood disorder	N	Y		35	Head Injury	N	Y	
6.	Rheumatic Fever	N	Y		36	Neck or Back injury	N	Y	
7.	Diabetes	N	Y		37	Leg/Knee/Hip/Ankle injury	N	Y	
8.	Hypoglycemia	N	Y		38	Repetitive strain	N	Y	
9.	Cardiac Disease	N	Y		39	Arthroscopy of a joint	N	Y	
10.	High Blood Pressure	N	Y		40	Herniated (slipped) disc	N	Y	
11.	Varicose veins or leg ulcer	N	Y		41	Surgical removal of a disc or a spinal fusion	N	Y	
12.	Thromobophlebitis(Inflammation) of vein or blood clot)	N	Y		42	Knee surgery	N	Y	
13.	Thyroid	N	Y		43	Any fracture or broken bones	N	Y	
14.	Hay fever/Asthma/Respiratory disorder	N	Y		44	Any other orthopedic surgery	N	Y	
15.	Chronic Cough	N	Y		45	Amputation of a body part	N	Y	
16.	Shortness of breath	N	Y		46	Chronic osteomyelitis (bone infection)	N	Y	
17.	Chest pain	N	Y		47	Osteoporosis	N	Y	
18.	Bloody sputum	N	Y		48	Residual disability from polio	N	Y	
19.	Total deafness/hearing loss/ ear problems	N	Y		49	Muscular dystrophy	N	Y	
20.	Mental Retardation/Learning disability	N	Y		50	Cerebral Palsy	N	Y	
21.	Eye/Vision conditions (glasses, contacts, color blindness, etc.)	N	Y		51	Multiple sclerosis	N	Y	
22.	Hernia (rupture)	N	Y		52	Ankylosing spondylitis	N	Y	
23.	Ulcers	N	Y		53	Have you ever had Chiropractic Treatment(s)	N	Y	
24.	Kidney or Bladder trouble	N	Y		54	Complications of pregnancy	N	Y	
25.	Hepatitis/Liver disease	N	Y		55	Disorders of the immune system (answer is optional)	N	Y	
26.	Parkinson's Disease	N	Y		56	Are there any question(s) above that you do not understand?	N	Y	
27.	Skin Trouble	N	Y			If so, which number(s)?			
28	Positive PPD (TB skin test)	N	Y		57	Elbow/Shoulder Injury	N	Y	
29	Tuberculosis	N	Y		58	Wrist/Arm Injury	N	Y	
30	Increased fatigue, night sweats	N	Y		59	Head Injury	N	Y	

Please review carefully to be certain that all questions in the previous chart have a response.

Last name:_____First name_____

INSTRUCTIONS: Circle "Y" for YES and "N" for NO to the following questions and give date. 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 had a major illness/injury in the past 5 years? N Y Explain: _____

_____

2.4 Have you had a CT Scan or MRI in the past five years? N Y Explain: _____

_____

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

_____

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

_____

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

Explain: _____

2.8 Is there any health related reason you may not be able to perform the essential functions of the job which you have been offered?

N Y Explain:_____

_____

2.9 Do you have any physical limitation which prevents you from performing certain kinds of work? N Y. If yes, Please describe the specific work limitation/restriction. _____

_____

2.10 Do you require any reasonable accommodations to perform the essential functions of your job, according to the job description? If so, please explain.

_____

3.1 Medication Allergies / Untoward Reactions? _____

_____

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? _____

Reviewer Comments: _____

_____

_____

Last name:_____First name_____

Immunization/Disease History: Please give the date you had the following diseases/immunizations/exposures to:

Chicken Pox Date:	Rubella(German Measles) Date:	Rubeola (Red Measles) Date:	MMR (Mumps/Meas/Rub) Date:	Tetanus/Diphtheria Date:
Hepatitis A Date:	Hepatitis B Date:	Hepatitis B Series Date	Hep B Titer Date:	Hepatitis C Date
Tdap Date:	Flu Vaccine Date:	Varicella: Date:	Meningococcal Date:	Other:_____ Date:

Tuberculosis Screening

Birth Country? _____ Last TB Test Date _____ □ Negative □ Positive □ Last chest x-ray? _____

BCG vaccinated? (vaccine for TB) □ No □ Yes - If YES, When? _____ Taken meds for TB? □ No □ Yes

Do you have the following:

Direct contact with patients	No___	Yes ___	Frequent fatigue	No___	Yes ___
Cough greater than 2 weeks	No___	Yes ___	Loss of appetite	No___	Yes ___
Night sweats	No___	Yes ___	Coughing up blood	No___	Yes ___
Persistent low grade fever	No___	Yes ___	Weak immune system	No___	Yes ___
Unexplained weight loss	No___	Yes ___	Frequent chills	No___	Yes ___
PPD allergy	No___	Yes ___	Chest pain	No___	Yes ___
Animal contact (at work)	No___	Yes ___ (If YES, name of species? _____			

N95 Respirator Use

a. Will you provide care for patients or research subjects that may have TB? □ **No** □**Yes**

b. Will you perform work duties that require you to wear a N95 Respirator? □ **No** □**Yes**

If yes to question a or b above, please COMPLETE the "RESPIRATOR MEDICAL EVAULATION QUESTIONNAIRE"

Respirator Medical Evaluation Questionnaire completed □ **No** □ **Yes** □ **N/A**

Bloodborne Pathogens

Complete Bloodborne Pathogens (BBP) Participation Questionnaire.

If answer *Yes* to any of the questions on the BBP Participation Questionnaire, you are required to have *initial* and *annual* training in BBP online at ulearn.miami.edu and completion of the *Hepatitis B Vaccine Form* below.

Hepatitis B Vaccine Form

If, in your position, you have the potential for exposures 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:

_____ **(initials) Request Series**

I understand that it is my responsibility to contact Employee Health at **305-243-3267** to schedule an appointment and to receive the vaccine. **This appointment is to be scheduled during the week of general orientation.**

_____ _____

Employee 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 declined 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.

In the future, if 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.

_____ **(initials) Decline Series**

_____ _____

Employee Signature Date:

Last name:_____ First name_____

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 the physical assessment. I authorize the medical practitioner to disclose all relevant medical information to the company regarding my medical history and assessment status.

Employee Name (Printed)_____

Signature of employee _____ Date _____

Reviewer (**PRINT NAME**)_____ Date _____

PLEASE DO NOT WRITE BELOW THIS LINE.

REVIEWER: Please review the form carefully to be certain that all questions have a response.

Reviewer Comments: _____

_____

_____

Name: _____

STOP- THIS CONCLUDES THE INFORMATION THE APPLICANT IS TO COMPLETE

THIS SECTION TO BE COMPLETED BY EXAMINER

PPD Skin Test (Mantoux)

Step 1

Date	Site	Lot #	Manufacturer	Exp date	Print Name

Date Read_____Results: _____mm (induration) □ Neg □ Pos

If positive, chest x-ray ordered? □ **No** □ **Yes** **Read by:** _____

Step 2

Date	Site	Lot #	Manufacturer	Exp date	Print Name

Date Read_____Results: _____mm (induration) □ Neg □ Pos

If positive, chest x-ray ordered? □ **No** □ **Yes** **Read by:** _____

OR

Blood drawn for TB (QFT)

DATE:	**Result:**

CXR Ordered/Date:

_____

Results:_____

Referral for Evaluation to:_____

_____

Repeat Testing Due:_____

Comments:

_____

_____

Physical Assessment

Height	Weight	Blood Pressure	Temp.	Pulse	Resp.

Additional Medical Information Needed RE: _____

Specify any physical restrictions/accommodations and expected duration of the restrictions/accommodations:

Lifting/Carrying/Climbing _____

Pushing/Pulling/Reaching _____ Stooping/Crawling/Kneeling _____

Standing/Sitting _____ Repetitive Motion _____

Other _____

Examiner (PRINT NAME) _____ **Date:** _____