University of Miami Health System
Employee Health Medical Questionnaire – Updated 3/2018

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_____EMPLOYEE ID# _____

ADDRESS _____ CITY/ZIP_____

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

DEPARTMENT_____SUPERVISOR_____

EMERGENCY CONTACT: (NAME) _____TELEPHONE _____ RELATIONSHIP. _____

Section A. **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?

		Yes or No	Date			Yes or No	Date
1.	Severe Headaches			31.	Nervous Breakdown, Mental Illness, Psychiatric treatment or counseling		
2.	Dizziness or fainting spells			32.	Arthritis/Rheumatism		
3.	Seizures			33.	Backaches		
4.	Epilepsy			34.	Head Injury		
5.	Anemia/Hemophilia/Other Blood disorder			35.	Neck or Back injury		
6.	Rheumatic Fever			36.	Leg/Knee/Hip/Ankle injury		
7.	Diabetes			37.	Repetitive strain		
8.	Hypoglycemia			38.	Arthroscopy of a joint		
9.	Cardiac Disease			39.	Herniated (slipped) disc		
10.	High Blood Pressure			40.	Surgical removal of a disc or a spinal fusion		
11.	Varicose veins or leg ulcer			41.	Knee surgery		
12.	Thromobophlebitis(Inflammation) of vein or blood clot)			42.	Any fracture or broken bones		
13.	Thyroid problems			43.	Any other orthopedic surgery		
14.	Hay fever/Asthma/Respiratory disorder			44.	Amputation of a body part		
15.	Chronic Cough			45.	Chronic osteomyelitis (bone infection)		
16.	Shortness of breath			46.	Osteoporosis		
17.	Chest pain			47.	Residual disability from polio		
18.	Total deafness/hearing loss/ ear problems			48.	Muscular dystrophy		
19.	Mental Retardation/Learning disability			49.	Cerebral Palsy		
20.	Bloody Sputum			50.	Multiple sclerosis		
21.	Eye/Vision conditions (glasses, contacts, color blindness, etc.)			51.	Ankylosing spondylitis		
22.	Hernia (rupture)			52.	Have you ever had Chiropractic Treatment(s)		
23.	Ulcers			53.	Complications of pregnancy		
24.	Kidney or Bladder trouble			54.	Disorders of the immune system *(answer is optional)*		
25.	Hepatitis/Liver disease			55.	Elbow/Shoulder Injury		
26.	Parkinson's Disease			56.	Wrist/Hand/Arm Injury		
27.	Skin problem/s			57.	Are there any question(s) above that you do not understand? If yes, which number(s)? _____		
28.	Tuberculosis						
29.	Alcoholism/Drug Addiction						
30.	Positive PPD (TB skin test)						

Please review carefully to be certain that ALL QUESTIONS in the previous SECTION have a response.

Section B. **INSTRUCTIONS: Circle "Y" for YES and "N" for NO to the following questions and give date. Do not skip any questions. Explain "YES" answers.**

1. Please list any condition or diseases for which you have been treated in the past 5 years. _____
2. Have you ever been hospitalized? If so, for what? _____
3. Have you had a major illness/injury in the past 5 years? Explain: _____
4. Have you had a CT scan or MRI in the past five years? Explain: _____
5. Have you ever had an injury, operation, disease or any disability not covered by the previous questions (sports, recreational, MVA, liability)? Explain: _____
6. Have you ever had or been treated for a Blood and Body Fluid Exposure (i.e. needlestick, splash, etc.)? Explain: _____
7. Any permanent physical condition that received an impairment rating? Explain: _____
8. Is there any health related reason you may not be able to perform the essential functions of the job for which you have been offered? Explain: _____
9. Do you have any physical limitation that prevents you from performing certain kinds of work? If yes, please describe the specific work limitation/restriction.
10. Do you require any reasonable accommodations to perform the essential functions of your job, according to the job description? Explain: _____
11. Medication Allergies / Untoward Reactions? _____
12. Other allergies or sensitivities? _____
    Latex Allergy? Animal Allergy? If animal allergy, please explain species _____
13. Please list all Prescription medications or over the counter drugs that you take on a regular basis: _____
14. Have you ever worked around or been exposed to any of the following?
    Chemotherapy Radiation Hazardous Chemical Laser
    When or Where?
15. Do you smoke/chew tobacco? If yes, how many packs per day? _____ Number of years? _____

Reviewer Comments: _____

Section C. **Immunization/Disease History: Please give the date you had the following immunizations or diseases:**

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:

Section D. **Tuberculosis Screening**

1. Date of Last TB Skin Test _____ ☐ Negative ☐ Positive
2. Date of Last Chest X-ray? _____ **Normal**? **If no, explain:** _____
3. BCG vaccinated? (vaccine for TB) ☐ No ☐ Yes - If YES, When? _____
4. Birth Country?_____
5. Direct contact with patients
6. Cough greater than 2 weeks
7. Night sweats
8. Persistent low grade fever
9. Unexplained weight loss
10. PPD allergy
11. Taken medications for TB? If YES, When? _____
12. Frequent fatigue
13. Loss of appetite
14. Coughing up blood
15. Weak immune system (due to disease, chemotherapy, steroids, etc. ***(answer is optional)***
16. Frequent chills

Section E. **Animal Contact at work**? *If yes, please complete Animal Contact Packet*

Section F. **Respirator use**

If you answer "Yes" to any of the 3 questions below, please complete the Respirator Medical Evaluation Questionnaire:

1. Do you enter rooms in which patients with known or suspected infectious TB are being isolated?
2. Are you present during cough-inducing or aerosol-generating procedures on patients with suspected or known TB?
3. Are you required to work in settings, other than those listed above, where administrative and engineering controls are not likely to protect you from inhaling infectious airborne TB germs? These settings include transporting patients who may have infectious TB in emergency transport vehicles and providing urgent surgical or dental care to patients who may have infectious TB before a determination has been made that the patient is non-infectious.

Section G. **Hepatitis B Vaccine**

In your position, do you have contact or potential contact with blood or other potentially materials?

Other potentially infectious materials include human body fluids, including semen, vaginal secretions, cerebrospinal fluid; any body fluid that is visibly contaminated with blood; and any combination of body fluids; and any unfixed tissue or organ (other than intact skin) from a human (living or dead).

If you answered YES, you must complete ONE of the following options (ACCEPT OR DECLINE).

If you DO NOT have contact or potential contact with blood or other potentially infectious materials **please continue to next page (*Section H). I have reviewed information on the Hepatitis B Vaccination Program and I choose to:***

1. **ACCEPT: _____ (initials) I accept the Hepatitis B vaccine.** I understand that it is my responsibility to contact the Employee Health Office at **(305)-325-5891** to schedule an **appointment during the week of general orientation.**

   OR

2. **DECLINE: _____ (initials) I DECLINE the Hepatitis B vaccine.** I decline the Hepatitis B vaccine at this time as I was previously vaccinated or I do not want the Hepatitis B Vaccine at this time. 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 the Hepatitis B Vaccine at no charge to myself. However, I decline Hepatitis B Vaccination at this time. I understand that if I was not previously vaccinated and 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 occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B Vaccine, I can receive the Hepatitis B Vaccine series at no charge to me.

Employee Signature: _____ Date:_____

Section H. **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 PRINTED NAME: _____**Employee Signature**_____**Date:** _____

PLEASE STOP. THIS CONCLUDES THE INFORMATION THE APPLICANT EMPLOYEE IS TO COMPLETE.

Section I. **THIS SECTION IS TO BE COMPLETED BY THE EXAMINER**
EXAMINER: Please review the form carefully to be certain that all questions have a response.

Tuberculosis (TB) Skin Test

Step 1

Visit 1 (Administer test)

Date Given	Site	Dose/Route	Drug Name	Lot#	Exp. Date	Manufacturer	Signature
		0.1ml/intradermal					
	Visit 2 (Reading)						
Date Read	Result	Size of Induration	Chest X-Ray Ordered?				Signature
			☐ **No** ☐ **Yes**				

Step 2

Visit 3 (Administer test)

Date Given	Site	Dose/Route	Drug Name	Lot#	Exp. Date	Manufacturer	Signature
		0.1ml/intradermal					
	Visit 2 (Reading)						
Date Read	Result	Size of Induration	Chest X-Ray Ordered?				Signature
			☐ **No** ☐ **Yes**				

OR

Blood drawn for TB (QFT)

DATE:	**Result:**

Physical Assessment

Height	Weight	Blood Pressure	Temp.	Pulse	Resp.

Vision Test

UNCORRECTED		**CORRECTED**		**ISHIHARA Result**
R 20/	**L 20/**	**R 20/**	**L 20/**	

Respirator Fit Test

Pass ☐ ☐ **Fail**	**Model#:** ☐ **N/A**

Additional medical information needed regarding: _____

Should be able to perform physical demands of this job description ☐ Yes ☐ No

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 _____

Comments: _____

Examiner PRINTED NAME: _____

Examiner Signature_____ **Date:** _____