EMPLOYEE HEALTH ASSESSMENT

Employee Name:	Date of Birth	Social Security Number

Medical/Psychosocial History

In the past two years have you been treated for any of the following: **If Yes, when**

Tuberculosis	_____	_____
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Chickenpox (Varicella)	_____	_____
Visual Impairment	_____	_____
Visual Impairment (corrected by glasses)	_____	_____
Hearing Impairment	_____	_____
Epilepsy or Seizure Disorder	_____	_____
Drug/Alcohol Abuse or Addiction	_____	_____
Psychiatric or Behavioral Disorder	_____	

Other:_____

If Yes, when

Have you ever been treated for Back Injury? _____ _____

Do you have any sensitivity or allergy to Latex products? _____

It is the employee's responsibility to seek treatment of allergies or conditions, and to notify the Coordinator of any allergy/condition, which could potentially interfere or limit job performance.

Have you ever received: **If Yes, when**

Workman's Compensation	_____	_____
Disability	_____	_____

Are you currently under the care of a physician? _____

If yes, please explain_____

List all prescription medications that you are currently taking:_____

TB Screening/Risk Assessment

1) Do you have a history of temporary or permanent residence (for >1 month) in a country with a high TB rate (i.e. any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)? _____
2) Do you have current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with an TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone >15mg/day for >1 month) or other immunosuppressive medication? _____
3) Have you had close contact with someone who has had TB disease? _____
4) Have you ever been treated for latent TB infection? _____
5) Do you have any of the following symptoms: Productive cough for more than 3 weeks; Coughing up blood; Unexplained weight loss; Fever, chills, or drenching night sweats for no known reason; Persistent shortness of breath; Unexplained fatigue for more than 3 weeks; Chest pain _____
6) Have you ever had a prior diagnosis of active TB, latent TB infection, a positive skin test, or positive blood test for TB? _____
7) Have you ever been treated with medication for TB or for a positive TB test? _____

I have read the above and declare that I have no injury, illness or ailment other than as specifically identified. I certify that I am not habituated to any depressants, stimulants, narcotics, drugs, alcohol, or other substances that may alter my behavior.

Employee Signature_____ **Date**_____

RN Signature _____ **Date**_____