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EMPLOYEE HEALTH SERVICES
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AEEmployeeHealthUWNI@UWHealth.org

HEALTH ASSESSMENT FORM

PERSONAL INFORMATION

NAME:		**HEALTH ASSESSMENT DATE:**	
TELEPHONE NUMBER:		**BIRTH DATE:**	
EMAIL ADDRESS:		**COUNTRY OF BIRTH:**	

Employee Health Services will need to understand more about your health history for the tasks we will be performing at your Pre-Employment Visit. Additionally, we need to ensure you are free of communicable diseases and you are safe to perform the essential functions of your job duties.

HEALTH HISTORY: PLEASE ANSWER ALL OF THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

Please list all health conditions, such as liver disease, heart disease, diabetes, and hypertension, in addition to operations and/or major injuries: Provide date(s) if possible.

Please list all allergies and type of reaction to allergen: all - including medications, foods and animals.

Alcohol use disorder: Yes ☐ No ☐ **Comments**

Substance use disorder: Yes ☐ No ☐ **Comments**

Current nicotine use: Yes ☐ No ☐ **Are you interested in quitting?** Yes ☐ No ☐

LATEX ALLERGY

Do you have an allergy to any rubber/latex products? i.e. Rubber gloves, balloons Yes ☐ No ☐ Unsure ☐

If yes, have you been tested/evaluated by a health care provider for this allergy? Yes ☐ No ☐

List the latex products you are allergic to, and the type of reaction you have/had:

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TUBERCULOSIS (TB) SCREENING

Most recent TB Skin Test	History of Positive TB Test	Have you received any vaccines in the past 4 weeks?
Date: ☐ Result: ☐	Yes ☐ No ☐ If yes, date: ☐	Yes ☐ No ☐ If yes, which ones? ☐

Have you ever taken medication (i.e. INH) for a positive TB test or active tuberculosis?	Chest X-Ray for TB
Yes ☐ No ☐ If yes, dates ☐	Yes ☐ No ☐ Date ☐ Result ☐

Are you experiencing any of the following?

	Yes	No		Yes	No
Persistent coughing	☐	☐	Unexplained weight loss	☐	☐
Coughing up bloody sputum or blood	☐	☐	Have you ever been told by a health care provider that you have had active TB?	☐	☐
Night sweats	☐	☐	Have you ever cared for or lived with anyone diagnosed with active TB?	☐	☐
Unexplained fatigue	☐	☐			
Recurring fever	☐	☐	Have you worked or volunteered in a setting where TB may be more common, e.g., homeless shelter, nursing home, group home or prison?	☐	☐

REVIEW OF SYSTEMS

Depending upon the responses to the below questions, the registered nurse (RN) reviewing this document may refer you for a follow-up appointment with your physician, nurse practitioner (NP), or physician's assistant (PA).

Instructions: Please check "Yes" or "No" depending on whether you have had a **SIGNIFICANT** history or **RECENT** problem with any listed items.

Are you experiencing any of the following?	Yes	No	Comments
Sore throat	☐	☐	
Cold sores	☐	☐	
Swollen lymph nodes	☐	☐	
Diarrhea	☐	☐	
Nausea/vomiting	☐	☐	
Drainage from eyes or ears	☐	☐	
Fever and respiratory symptoms (i.e. cough, runny nose)	☐	☐	
Fever and rash	☐	☐	

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REVIEW OF SYSTEMS

Are you experiencing any of the following?	Yes	No	Comments
Fainting/dizziness	☐	☐	
Heat Stroke/heat exhaustion	☐	☐	
Inability to tolerate extreme cold exposure (-30F with wind chill)	☐	☐	
Rashes, vesicles on skin/skin problems	☐	☐	
Headaches/migraines	☐	☐	
History of eye disorders or visual problems	☐	☐	
History of lens or cataract removal	☐	☐	
History of diseases which may affect vision (examples: diabetes, glaucoma, trauma to eye, retinal detachment)	☐	☐	
Difficulty hearing/hearing aids	☐	☐	
Slurred speech	☐	☐	
Breathing difficulty/shortness of breath/asthma	☐	☐	
Sleep apnea	☐	☐	
Chest pain	☐	☐	
Cancer	☐	☐	
Seizures	☐	☐	
Non healing wound	☐	☐	
Returned from travel in another country within the last 12 months	☐	☐	If yes, what country?
Difficulty walking	☐	☐	
Disc problems/sciatica	☐	☐	

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Are you experiencing any of the following?	Yes	No	Comments
Neck pain/back pain	☐	☐	
Joint problems	☐	☐	
Limited activities due to pain/injury	☐	☐	
Muscle weakness	☐	☐	
Use a brace, splint, or assistive devices	☐	☐	
Carpal tunnel syndrome or other hand/wrist problems	☐	☐	
Do you have any medical or psychological conditions (e.g., anxiety or depression) that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/request any modifications to your job duties?	☐	☐	

Vision screening questions

Do you have a current eye prescription? Yes (Bring documentation of most recent eye prescription) ☐ No ☐

RX type: Glasses ☐ Contacts ☐ Last eye exam by optometrist: Month/Year ☐

Have you ever been told by a physician or other health care provider that you have any of the following conditions?

	YES	NO	COMMENTS
Hepatitis A, B, or C	☐	☐	
HIV / AIDS	☐	☐	
Any other concerns you wish to discuss? If yes, please describe:	☐	☐	

WORK HISTORY

Question	YES	NO	COMMENTS
Have you ever had a work-related injury or illness? Please include any blood/body fluid exposure. (If yes, please describe)	☐	☐	

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Answer each of the following questions. Not all questions may apply to your position, and will be discussed at your appointment.

Do you have, or have you ever had any of the following? (Please check all that apply)

	YES	NO	COMMENTS
Difficulty sitting for long periods	☐	☐	
Difficulty moving or lifting patients	☐	☐	
Difficulty lifting objects weighing up to 50 pounds	☐	☐	
Difficulty lifting objects weighing up to 100 pounds	☐	☐	
Difficulty with stairs, ladders or heights	☐	☐	
Difficulty with repetitive lifting, bending, squatting, twisting, reaching, pushing, pulling, standing or walking	☐	☐	
Difficulty tolerating heat, cold or dampness	☐	☐	

FOR ALL JOB CLASSIFICATIONS

	YES	NO	COMMENTS
Do you have a documented disability? (If yes, describe)	☐	☐	
Do you require an accommodation because of the disability? If yes, please request the Accommodations Request Packet by contacting EHS @ 779-696-4112 and follow up with your provider. Please bring completed paperwork to your preemployment health assessment visit at Employee Health Services.	☐	☐	
Do you currently have any work restrictions? (If yes, describe and note if these are temporary or permanent)	☐	☐	

I acknowledge that the above information is true and correct to the best of my knowledge.

Any misrepresentations in the requested information may result in any conditional offers of employment being withdrawn.

Signature - Employee Completing Form *By electronically signing or typing your name below, you agree that it is the legal equivalent of your handwritten or original signature.*	Date Signed (MM/DD/YYYY)

For EHS RN use only

☐ Yes ☐ No I have conducted a screening and have reviewed the information on this form. The individual appears to be clinically free from communicable disease and TB.

☐ Yes ☐ No RN referral to physician, NP, or PA.

Signature - RN	**Name** - RN (print)	Date Signed (MM/DD/YYYY)