ThedaCare

HEALTH ASSESSMENT SCREENING

The following information is being requested for three reasons: FIRST: It will assist ThedaCare and its affiliates in evaluating your physical and mental capacity to perform a given position and to aide in placing you in a position which does not jeopardize your safety or others. SECOND: The information will provide baseline medical information which could be used for future reference and to help in case of an emergency. THIRD: This information will assist in attempting to accommodate any disability you might have.

THE INFORMATION YOU PROVIDE AND THE HEALTH SCREENING WILL ONLY BE USED FOR THE STATED REASONS AND WILL NOT BE USED TO DISCRIMINATE AGAINST ANY INDIVIDUAL ON THE BASIS OF ANY DISABILITY UNRELATED TO THE ABILITY TO PERFORM THE ESSENTIAL FUNCTIONS OF THE JOB, AS PROVIDED BY STATE AND FEDERAL LAW.

I have received a contingent offer of employment at ThedaCare, and voluntarily consent to a Health Assessment Screening process, medical history and lab tests to be performed at ThedaCare and/or its designee. If a condition is discovered that indicates the need for further treatment, I understand that I am personally and financially responsible for any medical care I choose to obtain based on these findings. I understand that this record and report shall become part of my Employee Health file and will be maintained as confidential information. I declare all information is accurate. I further understand that the offer extended to me is contingent on my ability to perform the minimum physical requirements of the position based on the findings of the Health Assessment Screening and evaluation of essential functions of the position.

I hereby authorize ThedaCare to perform a Health Assessment Screening. I understand that a Registered Nurse will be performing the Health Assessment Screening. This screening is done to determine my fitness to perform job functions. It does not take the place of a routine medical or complete physical examination. I am aware that I need to see my own physician for my personal health needs.

I understand the screening by ThedaCare is to determine my fitness to perform essential functions of the offered position for employment with ThedaCare.

Copies of TB skin tests, Lab tests and Health Assessments will be kept on file in the Employee Health Office and will be released as deemed necessary.

The information I have given in this questionnaire is true and complete to the best of my knowledge. Any attempt to withhold or misrepresent any information regarding past or present disabilities or illnesses may be considered grounds for termination or reduction in claim benefits.

Signature of Applicant:_____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

DEMOGRAPHIC DATA

(Please Print)

First Name: _____ M.I.: _____ Last Name: _____

S.S. #: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____) _____

Job Title: _____ Department: _____

Name of Personal Physician: _____

Location (City): _____

PS1249 ThedaCare Print Center/DK Rev 6/16

Work History

Applicant's Initial's _____

Yes	No		
❑	❑	1.	Do you have a disability?
❑	❑	2.	Will you need special arrangements for access to the building?
❑	❑	3.	Do you have any condition that may require a special work assignment or accomodation?
❑	❑	4.	Do you currently have any temporary or permanent job restrictions?
❑	❑	5.	Have you had an accident or injury in the past year?
❑	❑	6.	Have you had surgery in the past year?
❑	❑	7.	Have you lost more than five (5) consecutive days from work during the past year because of illness or injury?
❑	❑	8.	Have you ever had any lasting health effects from work you have done?

Comments: _____

General Health

Yes	No		
❑	❑	9.	Are you pregnant?
❑	❑	10.	Have you had any recent failing in your health or serious illness?
❑	❑	11.	Have you been advised to have surgery in the near future?
❑	❑	12.	Is a physician or other healthcare provider presently treating you?
❑	❑	13.	Do you have a chronic or serious illness? If yes, please list:_____
❑	❑	14.	Have you had any recent unexplained weight loss?
❑	❑	15.	Do you have a bleeding tendency?
❑	❑	16.	Do you have frequent or severe headaches that require medication?
❑	❑	17.	Do you have a lung problem (i.e., emphysema, chronic bronchitis or asthma)?
❑	❑	18.	Do you get out of breath long before anyone else?
❑	❑	19.	Do you have a problem with your eyes that cannot be corrected with glasses?
❑	❑	20.	Do you have a hearing problem or hearing loss?
❑	❑	21.	Do you have buzzing or ringing in your ears?
❑	❑	22.	Are you frequently dizzy?
❑	❑	23.	Have you ever seen a health care provider about your hearing?
❑	❑	24.	Have you been exposed to loud noise at work, in the military or in a hobby?

Comments: _____

Musculoskeletal

Yes	No		
❑	❑	25.	Do you have a back problem or had a back injury?
❑	❑	26.	Have you had a back problem that has caused you to miss work?
❑	❑	27.	Have you had surgery on your back?
❑	❑	28.	Do you have a neck problem or had a neck injury?
❑	❑	29.	Have you had a neck problem that has caused you to miss work?
❑	❑	30.	Have you had surgery on your neck?
❑	❑	31.	Have you seen a chiropractor in the last 5 years?
❑	❑	32.	Have you ever been told that you have arthritis or rheumatism?
❑	❑	33.	Have you ever had a shoulder injury?
❑	❑	34.	Have you ever had a hand or wrist injury?
❑	❑	35.	Have you ever had a leg injury?
❑	❑	36.	Have you ever had a hip injury?
❑	❑	37.	Have you ever had carpal tunnel syndrome?

Musculoskeletal Continued

Applicant's Initial's _____

Yes No

- ☐ ☐ 38. Have you ever had tendonitis?
- ☐ ☐ 39. Have you ever had tennis elbow?
- ☐ ☐ 40. Have you ever had bursitis?
- ☐ ☐ 41. Have you ever had a slipped disc?
- ☐ ☐ 42. Have you ever had sciatica?
- ☐ ☐ 43. Have you ever had any painful or swollen joints? If yes, please list: _____
- ☐ ☐ 44. Have you ever had numbness, tingling or pain in your hands at night?
- ☐ ☐ 45. Do you have paralysis of any part of your body? If yes, please list: _____
- ☐ ☐ 46. Do you have problems with your feet?
- ☐ ☐ 47. Do you have an amputation?

Explain any yes answers: _____

_____

Mental Health

Yes No

- ☐ ☐ 48. Have you ever been treated for anxiety or depression?

Comments: _____

Health Risks

Yes No

- ☐ ☐ 49. Do you use tobacco (cigarettes, cigars, pipes, chewing, E-cigarettes, vapor)?
- ☐ ☐ 50. Do you have diabetes?
- ☐ ☐ 51. Do you have epilepsy or a seizure disorder?
- ☐ ☐ 52. Have you ever had a hernia or hernia repair?
- ☐ ☐ 53. Have you had hepatitis?
- ☐ ☐ 54. Do you have or have you had tuberculosis (TB)?
- ☐ ☐ 55. Have you ever been rejected for employment because of health reasons?
- ☐ ☐ 56. Have you ever been told you had cancer?
- ☐ ☐ 57. Have you had blood clots in your legs?
- ☐ ☐ 58. Do you have chest pain, discomfort or tightness with exertion?
- ☐ ☐ 59. Have you ever had a heart problem?
- ☐ ☐ 60. Have you ever been told you had a heart murmur?
- ☐ ☐ 61. Do you have high blood pressure?
- ☐ ☐ 62. Have you ever had a stroke?
- ☐ ☐ 63. Have you had any hospitalizations or surgeries? If yes, please list:

Date: _____ Reason: _____

_____

_____

- ☐ ☐ 64. Are you currently taking any medications? If yes, please list: _____

_____

_____

- ☐ ☐ 65. Do you have or have you had any illness that is not mentioned in this questionnaire?

If yes, please explain: _____

Comments: _____

Allergies / Sensitivities

Yes No

- ❑ ❑ 66. Do you have any allergies or needed epinephrine for a reaction (food, medication, insect stings/bites)? If yes, please list: _____
- ❑ ❑ 67. Does your skin break out from detergents, soap or chemicals?
- ❑ ❑ 68. Do you have a history of eczema or other rashes on your hands?
- ❑ ❑ 69. Do you have a chronic skin rash?
- ❑ ❑ 70. Have you had testing for latex allergy? When: _____ Diagnosis: _____
- ❑ ❑ 71. Do you wear a medical alert bracelet?
- ❑ ❑ 72. Are you on any treatment / medications (including inhalers) for allergies? Explain: _____ Comments: _____

Additional explanation of "Yes" answers:

_____

_____

_____

Signature: _____ Date: _____

Reviewed by: _____ Date: _____

FOR OFFICE USE ONLY — PLEASE DO NOT COMPLETE

BP: _____ Color Vision: _____ Laser Exam: _____ Fit Test: _____

History of Infections/Immunizations

❑ Hepatitis B Series ❑ Completed ❑ In Progress ❑ Start ❑ Decline

❑ 2- MMR dates provided ❑ Rubella titer drawn ❑ Rubeola titer drawn ❑ Varicella titer drawn ❑ Mumps titer drawn

❑ 2- Varivax dates provided ❑ TD/Tdap up to date ❑ TD/Tdap given Most recent influenza vaccine date: _____

❑ TB test done ❑ #1 only ❑ needs #2 ❑ scheduled for 1-step/2-step

❑ Past positive TB skin test Date: _____ last CXR Date: _____ CXR Done

❑ Drug Screen ❑ Negative ❑ Positive HR notified on (date) _____ of DS results by (initials) _____

❑ Ergonomic Evaluation requested ❑ Referred to ThedaCare at Work for Pre-Placement Exam

❑ Unremarkable assessment ❑ Clear for employment

Provider Remarks: _____

_____

ThedaCare

Hepatitis B Vaccination Consent

First Name:	Last Name:	Date:
Employer Name:		
Date of Birth:	Age:	Gender:

☐ I request vaccination against Hepatitis B using the synthetically derived vaccine Recombivax HB or Engerix B (DO NOT take if hypersensitive to yeast). I have been given and read the Hepatitis B information statement.

☐ I do not wish to be vaccinated against Hepatitis B. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B (HBV) Infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine at no charge to myself; however, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

☐ I have already completed the Hepatitis B vaccine. The series was completed in _____ (year).

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

EMPLOYEE HEALTH USE ONLY

VACCINE DOSE		DATE	SITE (DELTOID)	LOT #	ADMINISTERING STAFF
Initial Dose	1				
1 Month Later	2				
6 Months later than initial dose	3				

HBs AB Titer (4-6 weeks after completion of series)

Date: _____ Result: ☐ Positive ☐ Negative

ThedaCare

EMPLOYEE HEALTH TUBERCULOSIS (TB) SKIN TEST QUESTIONNAIRE

First Name:	Last Name:	Date:
Employer Name:		
Date of Birth:	Age:	Gender:

PLEASE ANSWER ALL OF THE QUESTIONS BELOW

This information is used to determine whether or not to give the TB skin test:

1. Have you had a reaction to TB (tuberculosis) skin test (such as shortness of breath, rash, bruising, swelling, raised bruise area)? ☐ **YES** ☐ **NO**

2. Do you have a rash on your forearms? ☐ **YES** ☐ **NO**

3. Have you ever had a positive TB (tuberculosis) test (TB skin test or IGRA, TB blood Test) or TB (tuberculosis) disease? ☐ **YES** ☐ **NO**

Have you ever been treated for active or latent TB? ☐ **YES** ☐ **NO**
When? _____ Did you have a chest x-ray?_____

4. Have you received any live vaccines in the past four weeks? Please check all that apply:

☐MMR ☐Oral Polio ☐Varicella ☐Shingles ☐Smallpox ☐Yellow Fever ☐Oral Typhoid (TY21a)

5. Do you have any of the following symptoms?
   a. ☐ Cough for more than 3 weeks AND one or more of the following symptoms
   b ☐ Shortness of Breath
   c. ☐ Fever
   d. ☐ Night Sweats (without a cause)
   e ☐ Extreme Fatigue, Weakness
   f. ☐ Coughing up Blood
   g. ☐ Unexplained Weight Loss

This information is used to interpret the TB test:

6. Are there any reasons you think your immunity/resistance is low? (HIV, cancer, leukemia,)
Describe: _____ ☐ **YES** ☐ **NO**

7. Do you take **medications** that affect your immune system, such as for the treatment of ulcerative colitis, Crohn's disease, organ transplant, cancer, lupus, rheumatoid arthritis, autoimmune disease? **Medication(s)**: _____ (example: Prednisone, Humira) ☐ **YES** ☐ **NO**
For how long? _____

8. Have you had personal contact with anyone known to have tuberculosis? ☐ **YES** ☐ **NO**

9. Have you had any changes on a chest x-ray showing prior tuberculosis? ☐ **YES** ☐ **NO**

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10. Have you immigrated to the United States (US) within the last 5 years? ☐ **YES** ☐ **NO**
Where from? _____

11. Have you ever been an injectable drug user? ☐ **YES** ☐ **NO**

12. Have you worked with patients with TB ☐, or worked in a homeless shelter ☐, nursing home ☐, correctional facility ☐, long-term care ☐. (check the boxes that apply). ☐ **YES** ☐ **NO**

If so, was the facility in Milwaukee county, Alaska, California, Florida, Hawaii, New Jersey, New York, Texas or Washington DC? (circle the areas that apply)

Any other areas? ☐ **Where?** _____

13. Do you have diabetes, kidney disease, past gastric bypass surgery, unintentional weight loss? ☐ **YES** ☐ **NO**

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14. When was your most recent TB skin test? _____ Result? _____

15. Have you traveled to a foreign country or lived with someone from a foreign country? ☐ **YES** ☐ **NO**
When? _____ Where? _____ How long?_____

16. Were you born in the US? ☐ **YES** ☐ **NO**
If not, where were you born? _____ How long have you lived in the US? _____

17. Have you ever received a BCG shot (used to attempt protection from Tuberculosis not given in the United States but used in some foreign countries)? ☐ **YES** ☐ **NO**
If so, when? _____ (infancy, childhood, adulthood)

PATIENT SIGNATURE: _____ DATE: _____

STAFF REVIEWING QUESTIONNAIRE: _____ DATE: _____

Lewisohn et al. (2017). Official ATS, IDSA, CDC and prevention clinical practice guidelines: diagnosis of tuberculosis in adults and children. *Clinical Infectious Disease. http://cid.oxfordjournals.org/content/early/2016/12/08/cid.ciw694.long#sec-68*

Centers for Disease Control. (2014). Latent tuberculosis infection: a guide for primary care providers. Retrieved from http://www.cdc.gov/tb/publications/ltbi/diagnosis.htm
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