Caregiver Health History Form

Name: _____ Caregiver ID#: _____

Address: _____
(street, city, state, zip)

Phone: _____ Date of Birth: _____ Sex: ☐M ☐F

Department: _____ Job Title: _____

Date of Hire: _____ Hospital/Clinic Campus: _____ if "other", please explain: _____

Did you receive childhood vaccination? ☐Yes ☐No

Are you allergic to latex? ☐Yes ☐No Please list any other allergies: _____

Please list any chronic diseases: _____

TUBERCULOSIS (TB) SCREENING

Most recent TB testing date:_____ Most recent test results: _____ If "other", please describe:
_____

If "positive for TB", did you receive treatment? ☐Yes ☐No - date of your last chest x-ray: _____

Please select any/all symptoms you are currently experiencing:

☐ Coughing ☐ Fever ☐ Tiredness
☐ Coughing up blood ☐ Unexplained weight loss ☐ Night sweats

Have you ever had a positive TB skin test or blood test? ☐Yes ☐No

Have you ever taken medication for TB? ☐Yes ☐No - if "yes" when did you take medication and for how long?
_____

What is your country of birth? _____ if not US, What year did you immigrate to the US? _____

Have you had a BCG vaccine (international TB vaccine)? ☐Yes ☐No

Have you ever been in contact with someone who has TB disease? ☐Yes ☐No

Have you ever used injection drugs? ☐Yes ☐No

Do you have HIVB/AIDS? ☐Yes ☐No

Do you have any diseases that could affect your immune systems such as cancer, leukemia or other? _____

Do you have diabetes? ☐Yes ☐No

Do you have severe kidney disease? ☐Yes ☐No

Are you underweight or do you have a disease which affects how you absorb food and nutrients? ☐Yes ☐No

Have you had an intestinal bypass or gastrectomy? ☐Yes ☐No

Do you take any prescription medications? ☐Yes ☐No Please list:_____

I understand that Infection Control/ Caregiver Health must be notified if any of these TB symptoms develop in the future.

Employee Signature: _____ Date: _____

IMMUNIZATION/DISEASE HISTORY

Please check box if you have documentation of the following:

☐ Hepatitis A	☐ TDAP Immunization after age 19 years.
☐ Hepatitis B Immunization/Titer	☐ TB CXR report/INH if past positive
☐ Measles, Mumps, Rubella Immunization/Titer	☐ Influenza (October-March)
☐ Varicella Immunization/Titer	☐ Meningococcal Immunization

Please bring documentation of all vaccination/ titer records to onboarding.

All immunization, titer, and TB test information recorded during employment are available to your management. As a healthcare institution, we are required to know your immune status. If you are not immune, or have inadequate records, you and your direct supervisor will be notified via email.

Employee Signature: _____ Date: _____