UNIVERSITY of MARYLAND MEDICAL SYSTEM

	UM Baltimore Washington Medical Center		UM Rehabilitation and Orthopaedic Institute
	UM Capital Region Medical Center		UM Shore Regional Health
	UM Charles Regional Medical Center		UM St Joseph Medical Center
	UMMC Downtown Campus/UMMS Corporate	X	UM Upper Chesapeake Health
	UMMC Midtown Campus		

EMPLOYEE HEALTH SERVICES
Initial Employee Health Evaluation

Today's date: _____

Printed name – First name, Middle name, Last name:	Date of Birth:
_____	_____

The purpose of this evaluation is to screen you for communicable diseases, determine whether vaccinations are necessary to protect you and your patients, to clear you to use a respirator, and to determine whether you have any impairment that could affect your ability to perform the essential functions of the job that you have been offered. This is NOT meant to substitute for the comprehensive health assessments that your private doctor performs for your personal health.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employment Information

Title of job that you have been offered: **Job code (if known):**

Can you perform the essential functions of your job with or without reasonable accommodation? □ Yes □ No

If you answered "yes" to the previous question, but can perform the essential functions of your job only with reasonable accommodation, please describe the accommodation (modification) that you are requesting:

Are these accommodations: □ Permanent □ Temporary until:_____(provide date) **MD documentation may be required.**

Employee name:_____

Past Work

Please list your last 3 positions, starting with the most recent:

TITLE	DESCRIPTION	DUTIES	DATE
1.			
2.			
3.			

Exposure History

Mark an **X** in the box next to **ALL** items you **MIGHT** have been exposed to in your **PAST WORK**

□ Asbestos/silica	□ Grease and oil	□ Vibration	□ Hazardous wastes	□ Loud noise (above 85 decibels)
□ Dusts	□ Pesticides	□ Ethylene oxide/other gases	□ Plastics	□ Solvents/degreasers
□ Formaldehyde	□ Laboratory animals'	□ Lead/mercury/cadmium	□ Paints/isocyanates	□ Cytotoxic agents (e.g. chemo)
□ Welding	□ Epoxy resins	□ Benzene	□ Glutaraldehyde	□ Lasers

□ Latex products □ Blood or fluid exposures (HIV, Hep B, Hep C) □ Other chemicals: _____

Did you require medical treatment for the exposure(s) ? □ Yes □ No

Work Injuries

Have you ever had an illness or injury that was related to your job?	Yes	No
If 'yes':		
What was the injury or illness:		
Where did it happen (location):		
What was the date of the injury:		
Did you miss work?	Yes	No
If 'yes', for how long? _____		
Do you have any ongoing restrictions to your activity?	Yes	No
If 'yes', please describe restrictions:		

Current Health Status

General Health and Function				
How would you rate your general health? ***Circle one***	Poor	Fair	Good	Excellent
How often do you engage in brisk physical activity that lasts at least 30 minutes? ***Circle one***	Not at all	Rarely	2-3 times/ week	≥ 3 times/ week
Do you smoke? If **'yes'** what do you smoke? *Circle one* Cigarettes E-Cigarettes Cigars Pipe How many/often per day? _____ For how many years? _____ If **'no'** have you ever smoked? _____ For how many years? _____ When did you quit? _____			Yes	No
Do you use smokeless tobacco? Specify			Yes	No
Do you drink beer, wine, or hard liquor? Average less than 1 drink per day? Average 2 or more drinks per day?			Yes Yes Yes	No No No
Do you use illegal drugs now?			Yes	No
Have you ever used illegal drugs in the past? **If yes, what, when, how long?**			Yes	No
Are you currently using prescription pain killers?			Yes	No

Are you now or have you ever been treated or monitored for substance use (including illegal drugs, use of a legal drug that has not been prescribed to you, or alcohol)? If yes, list/describe substance, treatment program (name/location/frequency) and ongoing monitoring (e.g. repeat urine or blood tests**):**_____	Yes	No
Are you currently (or have you ever been) on a contract with your licensing board for a substance or alcohol use disorder ?	Yes	No

Latex Allergy Screening

a. Have you ever been told by a medical professional that you have a latex allergy?	Yes	No
b. Have you ever had difficulty breathing, wheezing or swelling of the face, mouth, lips or throat after contact with latex?	Yes	No
c. After handling latex products, have you ever experienced any of the following?		
Difficulty breathing or wheezing	Yes	No
Runny, itchy nose or congestion	Yes	No
Itching eyes/increased tearing	Yes	No
Systemic hives/rash	Yes	No
Itching or hives on hands	Yes	No
Swelling of hands	Yes	No
Redness of hands	Yes	No
Chapping or cracking of hands	Yes	No
d. Are you allergic to: ***Check all that apply*** □ Bananas □ Avocado □ Kiwi □ Other foods (list):_____		

Systems Review

Respiratory Clearance		
Have you ever worn a respirator? If 'yes' what type(s)? : _____	Yes	No
Did you have any difficulties when using the respirator (such as eye or skin irritation, anxiety, weakness or fatigue)? Explain:	Yes	No
Respiratory		
Have you had any chest injuries/surgeries in the past year or that are still causing pain or breathing problems?	Yes	No
Do you have current shortness of breath?	Yes	No
Very short of breath when walking fast on level ground or walking up a slight hill or incline?	Yes	No
Very short of breath when walking with other people at an ordinary pace on level ground?	Yes	No
Have to stop for breath when walking at your own pace on level ground?	Yes	No
Shortness of breath when washing or dressing?	Yes	No
Shortness of breath that interferes with your job?	Yes	No

Respiratory		
Coughing that:	Yes	No
Produces phlegm (thick sputum)	Yes	No
Wakes you early in the morning	Yes	No
Occurs mostly when you are lying down	Yes	No
Produces blood (in the last month)	Yes	No
Do you have wheezing?	Yes	No
Do you have wheezing that interferes with your job?	Yes	No
Have you ever had claustrophobia (fear of close-in-places) that interferes with wearing a respirator?	Yes	No
Do you have trouble smelling odors?	Yes	No

Cardiovascular		
Have you had any problems with chest pain/tightness:	Yes	No
While you are walking?	Yes	No
While you are resting?	Yes	No
Interfered with my job?	Yes	No
Do you have an irregular heartbeat or palpitations	Yes	No

Do you have swollen ankles/feet (not caused by walking)	Yes	No
Do you have heartburn or indigestion that is not related to eating	Yes	No
Do you have pain in your legs when walking that is not relieved by rest.	Yes	No
Have you ever had chest pain when you breathe deeply?	Yes	No
Do you have fatigue that may interfere with your job?	Yes	No
Musculoskeletal		
Do you have any problems with your joints or muscles?	Yes	No
Do you currently have neck pain, back pain, or pain in any of your joints?	Yes	No
Have you ever had an injury to your neck, back, extremities, or joints?	Yes	No
Have you ever had any broken bones including ribs? If **'yes'** what bone and when? _____ If **'yes'**, is it still causing pain?	Yes Yes	No No
Do you have trouble bending at the waist?	Yes	No
Do you have any lifting restrictions? If **'yes'**, describe restrictions (e.g. maximum weight you can lift): _____	Yes	No
Do you have trouble doing a deep knee bend?	Yes	No
Do you have trouble lifting your arms above your head?	Yes	No
Do you have trouble making a fist with both of your hands?	Yes	No
Do you have any limitations in the amount of time you are able to sit, stand, or walk?	Yes	No
Do you have trouble going up and down stairs?	Yes	No
Neurological		
Do you have loss of vision in either eye that **cannot** be corrected?	Yes	No
Do you have loss of vision requiring correction? If **'yes'** mark the type of correction _____ Reading _____Distance _____Contact Lenses _____Eyeglasses Do you have any problems with depth perception? Do you have any problem with loss of peripheral vision?	Yes Yes Yes	No No No
Do you have hearing loss that requires hearing aids?	Yes	No
Do you have headaches **more than twice a month**, which limits your ability to work?	Yes	No
Do you have problems with weakness (loss of strength)?	Yes	No
Do you have numbness or tingling in your extremities?	Yes	No
Do you or have you ever had seizures (fits)? If **'yes'** when was the last episode? _____	Yes	No
Do you have episodes of lightheadedness or dizziness? If **'yes'** when do these occur? _____	Yes	No
Have you ever passed out (fainted)? If **'yes'** when was the last episode? _____	Yes	No
Do you ever lose your coordination/balance?	Yes	No
Psychiatric		
Have you ever received treatment for, or missed work because of, any of the following:		
ADD or ADHD?	Yes	No
Depression?	Yes	No
Bipolar disease?	Yes	No
Anxiety?	Yes	No
Post-traumatic stress disorder (PTSD)?	Yes	No
Schizophrenia?	Yes	No
Other psychological/psychiatric disorder or other mental health problem?	Yes	No

Do you have decreased ability in any of the following? (Check all that apply) □ To stay awake or maintain consciousness (due to such causes as seizures, diabetes, or sleep disorder) □ Manage multiple tasks at one time □ Work rotating shifts	Yes	No

Medications

Do you have a history of allergies or sensitivities to medications?	Yes	No

If **'yes'** which medication(s)?

Name of Medication	Reaction	Name of Medication	Reaction

List all medications or nutritional supplements (such as vitamins, minerals, energy drinks) that you are currently taking both prescription **and** over-the-counter:

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

Chronic Conditions

Mark an X in the box next to any of the following illnesses you now have or have ever had.

☐ Heart attack or other heart problem	☐ Back problems/surgery	☐ Diabetes	☐ Lung disease	☐ Diverticulosis	☐ Skin disorder	☐ Liver disease
☐ High blood pressure	☐ Knee problems/surgery	☐ Cancer or tumor	☐ Current or frequent pneumonia	☐ GERD	☐ Hives	☐ Chronic Hepatitis B
☐ Peripheral vascular disease	☐ Ankle problems/surgery	☐ Anemia	☐ Pneumothorax (collapsed lung)	☐ Reflux	☐ Rashes	☐ Hepatitis C
☐ Heart failure	☐ Neck problems/surgery	☐ Kidney/ bladder problems	☐ Asthma	☐ Hernia	☐ HIV	☐ Color Blindness
☐ Stroke	☐ Shoulder problems/surgery	☐ Hypothyroid	☐ Other			

If you have marked an X next to any of the above, provide additional information including: when you were diagnosed with the condition, duration, complications, hospitalizations related to the condition, and any ongoing issues related to the condition:

Employee name:_____

By signing this form, I am certifying that to the best of my knowledge I have provided answers truthfully and will provide a doctor's note and/or medical records, as requested, to determine if I am medically fit to perform this job. I also understand that if Employee Health learns that I misrepresented facts, which includes omitting medical information, then Employee Health will inform Human Resources who will make a decision as to whether my job offer will be rescinded.

If I develop a new medical condition or experience changes in any previously reported medical condition(s) that would in any way impair or limit my ability to perform job duties or impact patient safety, after completion of the pre-placement health evaluation but before starting work, it is my responsibility to inform Employee Health Services of this information.

Your signature_____ Date _____

****

To be completed by Employee Health Services

Physician/CRNP/RN/MA reviewing medical history _____ Date _____

Outstanding issues:

Blood Pressure	Manual Blood Pressure	Pulse	Weight:	Height:
_____/_____	_____/_____	_____	_____	_____
L R	**L R**			

Visual Acuity: □ W/Correction **glasses contacts** □ W/O Correction R Eye: 20/_____ L Eye: 20/_____ Both Eyes: 20/_____ Vision indication for MD note, glasses or contacts (20/50)	***Color Vision Screening*** □ Normal □ Abnormal □ How many missing:_____

BBP Review_____