|  |  |  |  |
| --- | --- | --- | --- |
|  | 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 |
| **X** | UMMC Downtown Campus/UMMS Corporate |  | UM Upper Chesapeake Health |
|  | UMMC Midtown Campus |  |  |

**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.**

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.

***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.***

**EMPLOYEE HEALTH SERVICES Today’s date:**

**Initial Employee Health Evaluation**

**Employment Information**

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

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

**Past Work**

**Work Injuries**

Yes

Yes

Yes

No

No

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?

  If ‘yes’, for how long? \_\_\_\_\_\_\_\_\_\_\_\_

  Do you have any ongoing restrictions to your activity?

If ‘yes’, please describe restrictions:

Have you ever had an illness or injury that was related to your job?

**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**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Are you currently (or have you ever been) on a contract with your licensing board for a substance or alcohol use disorder ?**  **Latex Allergy Screening** | | | Yes  Yes | No  No |

|  |  |  |
| --- | --- | --- |
| 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  Runny, itchy nose or congestion  Itching eyes/increased tearing  Systemic hives/rash  Itching or hives on hands  Swelling of hands  Redness of hands  Chapping or cracking of hands | Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes | No  No  No  No  No  No  No  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)? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did you have any difficulties when using the respirator (such as eye or skin irritation, anxiety, weakness or fatigue)? Explain: | Yes    Yes | No    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?**  Very short of breath when walking fast on level ground or walking up a slight hill or incline?  Very short of breath when walking with other people at an ordinary pace on level ground?  Have to stop for breath when walking at your own pace on level ground?  Shortness of breath when washing or dressing?  Shortness of breath that interferes with your job? | Yes  Yes  Yes  Yes  Yes  Yes | No  No  No  No  No  No |

|  |  |  |
| --- | --- | --- |
| **Respiratory** |  |  |
| **Coughing that:**  Produces phlegm (thick sputum)  Wakes you early in the morning  Occurs mostly when you are lying down  Produces blood (in the last month) | Yes  Yes  Yes  Yes  Yes | No  No  No  No  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:**  While you are walking?  While you are resting?  Interfered with my job? | | Yes  Yes  Yes  Yes | | No  No  No 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**

**Systems Review *cont’d***

|  |  |  |
| --- | --- | --- |
| 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 |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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**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: | | | | | | |

**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, or failed to disclose medical information including but not limited to failing to disclose medical conditions, medications as well as medical marijuana, 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**To be completed by Employee Health Services**

Physician/CRNP/RN/MA reviewing medical history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outstanding issues:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Blood Pressure  **\_\_\_\_\_\_/\_\_\_\_\_\_**  **L R** | Manual Blood Pressure  **\_\_\_\_\_\_/\_\_\_\_\_\_**  **L R** | Pulse  \_\_\_\_\_\_\_ | | Weight:  \_\_\_\_\_\_\_\_ | Height:  \_\_\_\_\_\_\_ |
| 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_