

Resident and Fellow Health Assessment

FULL NAME _____
(LAST) (FIRST) (MIDDLE) DATE

HOME ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME TELEPHONE _____ BIRTH DATE _____ SEX _____
(AREA CODE)

SOCIAL SECURITY NUMBER _____

PERSONAL PHYSICIAN OR CLINIC _____ START WORK DATE _____
(NAME)

_____ PROGRAM _____
(ADDRESS)

_____ JOB TITLE _____
(PHONE)

Instructions: *You will not be able to start your training program until this requirement has been met.*

- Complete this Health Assessment Form and gather required documentation.
- Schedule an appointment with UWHC employee Health Service at least one week prior to your start date.
- Complete necessary follow-up.

Health History

1. Major illnesses/health conditions and hospitalizations (describe and give year):

2. Operations (describe and give year):

3. Major injury (describe and give year):

4. Allergies (*including reactions to drugs and latex – also see attached questionnaire on latex allergies(pink)*):

Exposures:

Type of exposure and date(s)	yes	no	unsure	date
Radiation	yes	no	unsure	date
Solvents	yes	no	unsure	date
Noxious fumes and gases	yes	no	unsure	date
Blood/Body fluids	yes	no	unsure	date

Comments: Include nature of exposure, follow-up tests/examinations etc.

Current Health Practices:

1. Medications

Prescriptions:

Non-Prescription (i.e., aspirin, vitamins, etc.):

2. Alcohol use: yes no Type_____Amount_____

Has anyone ever been concerned about your alcohol use? yes no

3. Tobacco use: yes no Onset_____Type_____Amount_____Quit Attempts_____

Have you ever tried to quit? yes no Do you want to? yes no

4. Exercise: (Type/Amount)

5. Hobbies/Recreational Activities:

6. Wear seat belts? yes no

Review of Systems

*INSTRUCTIONS-Please check () "yes", "no" or "unsure" depending on whether you have had a **SIGNIFICANT** or **RECENT** problem with any of the listed items.*

	Yes	No	Unsure	Comments
General				
Recent weight change	_____	_____	_____	
Fever/chills/night sweats	_____	_____	_____	
Increased drinking/urinating	_____	_____	_____	
Lumps/masses/tumors	_____	_____	_____	
Dizziness/light-headedness	_____	_____	_____	
Fainting	_____	_____	_____	
Headaches	_____	_____	_____	
Itching/Hives	_____	_____	_____	
Rashes/Skin Problems	_____	_____	_____	
Thyroid disorder	_____	_____	_____	
Cancer	_____	_____	_____	
Easy bruising or bleeding	_____	_____	_____	
Fatigue	_____	_____	_____	
History of Blood Transfusions	_____	_____	_____	
Eye, Ear, Nose, and Throat				
Eye Pain	_____	_____	_____	
Glaucoma	_____	_____	_____	
Blurred or double vision	_____	_____	_____	
Use glasses or contact lenses	_____	_____	_____	
Loss of hearing	_____	_____	_____	
ringing in ears	_____	_____	_____	
Drainage from ears	_____	_____	_____	
Trouble with nose or sinuses	_____	_____	_____	
Teeth or gum problems	_____	_____	_____	
Use dentures	_____	_____	_____	

History of X-Ray therapy to head or
neck

	Yes	No	Unsure	Comments
Musculoskeletal				
Neck or back pain	_____	_____	_____	
Joint problems	_____	_____	_____	
Muscle weakness	_____	_____	_____	
Night cramps	_____	_____	_____	
Use a brace or splint	_____	_____	_____	
Carpel tunnel	_____	_____	_____	
Respiratory				
Cough	_____	_____	_____	
Sputum/phlegm production	_____	_____	_____	
Pneumonia or pleurisy	_____	_____	_____	
Shortness of breath with activity	_____	_____	_____	
Wheezing or asthma	_____	_____	_____	
Pulmonary emboli (blood clot to the lung)	_____	_____	_____	
Used tobacco in the past	_____	_____	_____	
Cardiovascular				
Palpitations	_____	_____	_____	
Chest pain	_____	_____	_____	
Heart disease	_____	_____	_____	
High blood pressure	_____	_____	_____	
Rheumatic fever	_____	_____	_____	
Ankle swelling	_____	_____	_____	
Shortness of breath at night	_____	_____	_____	
Pain in legs with activity	_____	_____	_____	
Blood clots (thrombophlebitis)	_____	_____	_____	
Difficulty breathing when lying flat	_____	_____	_____	
Gastrointestinal				
Abdominal pain	_____	_____	_____	
Nausea or vomiting	_____	_____	_____	
Bloating or food intolerance	_____	_____	_____	
Peptic ulcer disease	_____	_____	_____	
Liver disease/hepatitis	_____	_____	_____	
Jaundice	_____	_____	_____	
Gall bladder disease	_____	_____	_____	
Diarrhea	_____	_____	_____	
Constipation	_____	_____	_____	
Blood in stool	_____	_____	_____	
Genitourinary				
Pain or burning with urination	_____	_____	_____	
Difficulty starting or holding urine	_____	_____	_____	
Urinary or bladder infections	_____	_____	_____	
Kidney or bladder stones	_____	_____	_____	
Blood in the urine	_____	_____	_____	

	Yes	No	Unsure	Comments
Possibly pregnant	_____	_____	_____	
Change in menstrual pattern	_____	_____	_____	
Other menstrual problems	_____	_____	_____	
Unusual vaginal discharge or bleeding	_____	_____	_____	
Pain or lump in testicles or scrotum	_____	_____	_____	
Other	_____	_____	_____	

Breasts

Lumps	_____	_____	_____
Tenderness	_____	_____	_____
Drainage from nipple	_____	_____	_____
Monthly breast self-exam	_____	_____	_____

Neuropsychiatric

Seizures	_____	_____	_____
Tremor	_____	_____	_____
Difficulty with walking	_____	_____	_____
Stroke	_____	_____	_____
Memory loss	_____	_____	_____
Black out spells	_____	_____	_____
Anxiety	_____	_____	_____
Depression	_____	_____	_____
Difficulty sleeping	_____	_____	_____
Hospitalization for psychiatric problems	_____	_____	_____
Sought professional help about a nervous disorder, mental problem, emotional difficulty, drug/alcohol problem	_____	_____	_____

Any other concerns you wish to discuss? Yes No
 Describe _____

Do you have a disability? Yes No

Do you require an accommodation because of the disability? Yes No
 If yes, please describe _____

Do you currently have any work restrictions? Yes No
 If yes, please describe _____

Immunizations and Infection Control*

Please provide documentation (day/month/year) of vaccines and/or antibody titers as requested below. **This information is required before you start your work at University of Wisconsin Hospital and Clinics. Please attach records/titer results.** You can obtain this information from your school, vaccine record, and physician’s records. If you are unable to find this information, you may get the vaccines/titers/TB skin test through your own physician’s office (at your expense) or have this done in Employee Health Service before your first day of work. Please call EHS if you have any questions.

Measles-Mumps-Rubella (MMR)

MMR #1 _____

MMR #2 _____

OR

Rubeola (Red Measles)

Dates of Vaccine: (1) _____ (2) _____

Date of Titer & Result: _____

Mumps

Dates of Vaccine: (1) _____ (2) _____

Date of Titer & Result: _____

Rubella (German measles)

Date(s) of Vaccine: (1) _____ (2) _____

Date of Titer & Result: _____

AND

Chicken Pox

Date of Disease: _____

Dates of Vaccine: (1) _____ (2) _____

Date of Titer & Result: _____

Hepatitis B

Dates of Vaccine: (1) _____ (2) _____ (3) _____

Date of Hepatitis B titer (anti-HBs): _____ Result: _____

Tetanus dT or Tdap (circle one): Date of last Vaccine: _____

*Current CDC guidelines state that health care workers (HCWs) born in/after 1957 need to have two doses of MMR given on/after their first birthday. If MMR vaccines were not given, the individual vaccines given at different times are acceptable if two doses of the vaccine were given on/after their first birthday. One dose of rubella vaccine satisfies the rubella immunity documentation.

1. For HCWs who do not have vaccine records; titers to the above diseases indicating immunity are acceptable.
2. HCWs born before 1957 will need to provide: 1) Titers to the above disease indicating immunity OR 2) One dose of MMR vaccine given on/after their first birthday.
3. For those certain they had chickenpox, date of disease is sufficient. If no history or unsure of history of chickenpox, a titer indicating immunity or two doses of the varicella vaccine are required.

Tuberculosis

Date & Result of most recent TB skin test: _____

(EHS will give TB test at health screening if no documentation of having a TB test within 6 months of start date)

If had BCG vaccine; Date : _____

History of Positive TB Skin Test: Bring documentation of Positive TB test/Chest X-ray/Treatment

Respirator/TB Mask (also complete attached yellow Mask Evaluation and Fit Test form)

If you have been fit tested for a N-95 Respirator/TB Mask in the past, please complete the following:

Date Fitted _____ Where Fitted _____

Mask Type (circle): 3M (oval) Tecnol (duckbill): Size _____

House Officer Attestation:

I have reviewed the information provided regarding the following:

- biohazard injury management.(green)
- occupationally acquired infection in health care workers (blue)

If you have questions about this health assessment, the easiest way to reach me is: _____

Signature: _____ Date: _____

Certification by Approved Health Care Provider:

To be completed by approved health care provider outside the UWHC Employee Health Service. This is only necessary if you are unable to meet with the UWHC Employee Health Service prior to your start date.

I have reviewed this health assessment. If you have any questions regarding this health assessment, please feel free to contact me.

Signature: _____

Name: _____

Title _____

Institution: _____

Phone Number: _____

Comments:

FOR EHS USE ONLY

New Employee Health Assessment Summary

Check if Done:

- _____ Biohazard Injuries/Exposures (Reporting mechanisms and follow-up)
- _____ Worker Compensation Reporting
- _____ Others:
- _____ Immunizations and Childhood Diseases Reviewed
- _____ Labs Ordered _____ PPD Given
- _____ Fit for Position
- _____ Further Assessment Needed Before Cleared to Work
 - _____ Titers _____
 - _____ PPD _____
 - _____ Urine Drug Screen _____
 - _____ Outside Records _____
- _____ Restrictions: Permanent _____ Temporary _____
- _____ Cleared for Work
- _____ Not Cleared for Work: Reason _____
- _____ Graduate Medical Education Office Notified

EHS Signature: _____