

**EMPLOYEE HEALTH SERVICE - UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS**  
**800 University Bay Drive, MADISON, WI 53705 (608) 263-7535 FAX: (608) 262-7284**

**HEALTH ASSESSMENT**

FULL NAME \_\_\_\_\_ DATE \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)  
HOME ADDRESS \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)  
HOME TELEPHONE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_  
(AREA CODE)  
SOCIAL SECURITY NUMBER \_\_\_\_\_

PERSONAL PHYSICIAN OR CLINIC \_\_\_\_\_ DATE STARTED WORK \_\_\_\_\_  
\_\_\_\_\_  
(NAME) UNIT/DEPT \_\_\_\_\_  
\_\_\_\_\_  
(ADDRESS) JOB TITLE \_\_\_\_\_  
\_\_\_\_\_  
(PHONE) SHIFT \_\_\_\_\_  
FULL TIME \_\_\_\_\_ PART- TIME \_\_\_\_\_  
PERMANENT \_\_\_\_\_ LTE \_\_\_\_\_

**⇒ PLEASE ANSWER ALL THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. COMPLETE THE QUESTIONNAIRE AND BRING IT WITH YOU FOR YOUR SCHEDULED APPOINTMENT.**

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):

**Exposures:**

Type of exposure and date(s)

Radiation yes no unsure date(s) \_\_\_\_\_  
Solvents yes no unsure date(s) \_\_\_\_\_  
Noxious fumes and gases yes no unsure date(s) \_\_\_\_\_  
Blood/Body fluids yes no unsure date(s) \_\_\_\_\_

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

**Infectious Disease and Immunizations: (MANDATORY FOR EMPLOYMENT)**

Please provide specific dates (day/month/year) of physician-documented illness, titer or date of immunization for the following childhood diseases. (Sources of information to assist you would be: Immunization records from parents, school or physicians office.)

	Had Illness	Immunized	Date
Rubeola (Red Measles) (2 doses required if born in/after 1957)	yes no unsure	yes no unsure	1. _____ 2. _____
Mumps	yes no unsure	yes no unsure	_____
Rubella (German Measles)	yes no unsure	yes no unsure	_____
MMR Vaccine		yes no unsure	1. _____ 2. _____
Chicken Pox	yes no unsure	yes no unsure	1. _____ 2. _____
Polio	yes no unsure	yes no unsure	
Tetanus Vaccine		yes no unsure	_____

**TB skin test**

Never Had a TB Skin Test (circle)

Most recent TB skin test Date\_\_\_\_\_Result\_\_\_\_\_

Positive TB Skin Test yes no Date of Positive Test\_\_\_\_\_

Chest X-ray yes no Date\_\_\_\_\_Result\_\_\_\_\_

Have you ever taken INH (isoniazid) for a positive TB skin test or medications to treat tuberculosis? no yes: Date\_\_\_\_\_

BCG (vaccine for TB) yes no unsure Date\_\_\_\_\_

Hepatitis B Vaccine yes no Date completed series\_\_\_\_\_

Anti Hbs titer drawn? yes no Date\_\_\_\_\_Result\_\_\_\_\_

Have you been exposed to blood or body fluids in the course of your work through needlestick/sharps injuries or mucous membrane exposures? yes no Date(s)\_\_\_\_\_

If yes, have you been tested for HIV and counselled regarding the proper follow-up? yes no

Comments:\_\_\_\_\_

**Current Health Practices: Please circle "yes" or "no" or fill in the blanks**

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. Recreational drug use: yes no Type\_\_\_\_\_Amount\_\_\_\_\_

4. Tobacco use: yes no Onset\_\_\_\_\_Type\_\_\_\_\_Amount\_\_\_\_\_Quit Attempts\_\_\_\_\_

5. Exercise: (Type/Amt)\_\_\_\_\_

6. Hobbies/Recreational Activities\_\_\_\_\_

7. Wear seat belts? yes no

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

**REVIEW OF SYSTEMS**

	Yes	No	General Unsure	Comments
Recent weight change	___	___	___	_____
Fever/chills/night sweats	___	___	___	_____
Increased drinking/urinating	___	___	___	_____
Lumps/masses/tumors	___	___	___	_____
Dizziness/light-headedness	___	___	___	_____
Fainting	___	___	___	_____

Headaches	___	___	___	_____
Itching/Hives	___	___	___	_____
Rashes/Skin Problems	___	___	___	_____
	<b>Yes</b>	<b>No</b>	<b>General Unsure</b>	<b>Comments</b>
Thyroid disorder	___	___	___	_____
Cancer	___	___	___	_____
Easy bruising or bleeding	___	___	___	_____
Fatigue	___	___	___	_____
History of Blood Transfusions	___	___	___	_____

**Eye, Ear, Nose, and Throat**

	<b>Yes</b>	<b>No</b>	<b>Unsure</b>	<b>Comments</b>
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	___	___	___	_____
Hoarseness	___	___	___	_____
History of X-Ray therapy to head or neck	___	___	___	_____

**Breasts**

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

**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**

Yes    No    Unsure    Comments

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 (both sexes)**

Pain or burning with urination	___	___	___	_____
Difficulty starting or holding urine	___	___	___	_____
Urinary or bladder infections	___	___	___	_____
Kidney or bladder stones	___	___	___	_____
Blood in the urine	___	___	___	_____
Discharge from the urethra	___	___	___	_____
Possibly pregnant	___	___	___	_____
Change in menstrual pattern	___	___	___	_____
Other menstrual problems	___	___	___	_____
Unusual vaginal discharge or bleeding	___	___	___	_____
Other (describe)	___	___	___	_____
Pain or lump in testicles or scrotum	___	___	___	_____
Other	___	___	___	_____

**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 \_\_\_\_\_



## FOR EHS USE ONLY

### New Employee Health Assessment Summary

Check if Done:

- Biohazard Injuries/Exposures (Reporting mechanisms and follow-up)  
 Back Safety and Lifting Precautions  
 Worker Compensation Reporting  
 Others:

- Immunizations & 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

Recommendations:  None  Yes

Increase Exercise     Decrease Weight     Dietary Recommendations  
 Seatbelts             BSE                     Smoking Cessation  
 Exercise               Stress Management     Other

Cleared for work

Not Cleared for Work: Reason: \_\_\_\_\_

Human Resources notified – e-mailed HR staffing group

Supervisor notified – e-mailed supervisor \_\_\_\_\_

Supervisor Name

Reviewed By

Date