EMPLOYEE HEALTH SERVICES
700 University Bay Drive, Suite 101
Madison, WI 53792
P: (608) 263-7535 F: (608) 262-7284
hremployeehealth@uwhealth.org

HEALTH ASSESSMENT FORM

PERSONAL INFORMATION

NAME	TODAY'S DATE	
TELEPHONE NUMBER	**COUNTRY OF BIRTH**	**BIRTH DATE**
EMAIL ADDRESS		

PRIMARY HEALTH CARE PROVIDER/CLINIC

NAME	TELEPHONE NUMBER
ADDRESS	

HEALTH HISTORY: PLEASE ANSWER ALL OF THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

Describe and give year of any health conditions, operations and/or major injuries:

Allergies (medications and/or food; include reactions):

Prescription Medications

Alcohol Abuse/ Alcoholism YES ☐ NO ☐	**Drug Abuse/ Addiction** YES ☐ NO ☐	**Tobacco Use** YES ☐ NO ☐	**Are you interested in quitting?** YES ☐ NO ☐

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LATEX ALLERGY

Do you have an allergy to any rubber/latex products? YES ☐ NO ☐ UNSURE ☐

If yes: Have you been tested/evaluated by a health care provider for this allergy? YES ☐ NO ☐

List the products you are allergic to:

Describe the type of reaction you have:

If no: Have you had any skin rashes or breathing problems after handling or being exposed to any of the following products?

Rubber Gloves	YES ☐	NO ☐	Reaction:
Balloons	YES ☐	NO ☐	Reaction:
Other rubber products?	YES ☐	NO ☐	Reaction:

TUBERCULOSIS (TB)

Previous TB Skin Test	Most recent TB Skin Test	History of Positive TB Skin Test	BCG (Vaccine for TB)
YES ☐ NO ☐	Date / Result	YES ☐ NO ☐ If yes, date:	YES ☐ NO ☐ UNSURE ☐ If yes, date

Have you ever taken medication (i.e. INH) for a positive TB Skin Test or active tuberculosis?	Chest X-Ray for TB
YES ☐ NO ☐ If yes, Date	YES ☐ NO ☐ Date / Result

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REVIEW OF SYSTEMS

Instructions: Please check "Yes" or "No" depending on whether you have had a SIGNIFICANT history or RECENT problem with any listed items.

Question	YES	NO	COMMENTS
Recent weight change	☐	☐	
Fever/chills/night sweats	☐	☐	
Fainting	☐	☐	
Headaches/Migraines	☐	☐	
Rashes/Skin problems	☐	☐	
Cancer	☐	☐	
Fatigue	☐	☐	
Difficulty hearing/hearing aids	☐	☐	
Deafness	☐	☐	
Cough	☐	☐	
Liver disease/hepatitis	☐	☐	
Diarrhea	☐	☐	
Spleen removed	☐	☐	
Nausea/Vomiting	☐	☐	
Neck pain	☐	☐	
Back pain	☐	☐	
Disc problems/Sciatica	☐	☐	
Limited activities due to pain/injury	☐	☐	
Joint problems	☐	☐	
Muscle weakness	☐	☐	

Question	YES	NO	COMMENTS
Use a brace or splint	☐	☐	
Use of assistive devices	☐	☐	
Carpal tunnel syndrome	☐	☐	
Other hand/wrist problems	☐	☐	
Difficulty walking	☐	☐	
Seizures	☐	☐	
Do you have any medical or psychological conditions (e.g., anxiety or depression) that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/ request any modifications to your job duties?	☐	☐	
While working with patients, there is the potential for mutual exposures to blood borne pathogens and communicable diseases. You have an ethical obligation to disclose any chronic communicable disease or blood borne pathogen infection, such as HIV, Hepatitis C, or Hepatitis B, prior to placement. Do you have a communicable disease or blood borne pathogen infection?	☐	☐	
Any other concerns you wish to discuss? If yes, please describe:	☐	☐	

WORK HISTORY

Question	YES	NO	COMMENTS
Have you ever had a job-related injury or illness? Please include any blood/body fluid exposure. (If yes please describe)	☐	☐	

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Answer each of the following questions. Not all questions may apply to your position, and will be discussed at your appointment.

Do you have, or have you ever had any of the following? (Please check all that apply)

Question	YES	NO	COMMENTS
Difficulty sitting for long periods	☐	☐	
Difficulty moving or lifting patients	☐	☐	
Difficulty lifting objects weighing up to 50 pounds	☐	☐	
Difficulty lifting objects weighing up to 100 pounds	☐	☐	
Difficulty with stairs, ladders or heights	☐	☐	
Difficulty with repetitive lifting, bending, squatting, twisting, reaching, pushing, pulling, standing or walking	☐	☐	
Difficulty tolerating heat, cold or dampness	☐	☐	

FOR ALL JOB CLASSIFICATIONS

Disability/ Restrictions	YES	NO	COMMENTS
Do you have a documented disability? (If yes, describe)	☐	☐	
Do you require an accommodation because of the disability? (If yes, describe)	☐	☐	
Do you currently have any work restrictions? (If yes, describe and note if these are temporary or permanent)	☐	☐	

Additional information may be requested from my doctor(s)/health care provider(s) should any information be needed to clarify my ability to do the job for which I am applying. My responses on this form are true and correct to the best of my knowledge.

Any misrepresentations in the requested information may result in any conditional offers of employment being withdrawn.

Signature **Date**

Reviewer **Date**