

**CONTINUUM HEALTH PARTNERS/LONG ISLAND COLLEGE HOSPITAL
 INITIAL HEALTH ASSESSMENT**

PLEASE PRINT ALL INFORMATION IN INK CLEARLY AND LEGIBLY

DATE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

LAST NAME: _____ FIRST: _____

SEX: MALE__ FEMALE__ MEDICAL RECORD # _____

HOME ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE/home: () _____ Other: () _____

NOTIFY IN CASE OF EMERGENCY PERSONAL PHYSICIAN

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

TELEPHONE: _____ TELEPHONE: _____

DEPARTMENT: _____ UNIT _____ JOB TITLE _____

SUPERVISOR'S NAME: _____ SHIFT: DAYS__ EVENINGS__ NIGHTS

DATE OF HIRE: _____ WORK PHONE# _____

STATEMENT OF PURPOSE AND CONFIDENTIALITY

This Initial Health Assessment is required by the New York State Department of Health Code, which in Section 405.3 (11) requires... assessment of the health status of all personnel, to assure that personnel are free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of duties.

The relationship between an employee Employee Health /Occupational Medicine (LICH/EHS) is confidential. Medical Information will only be released when and if prescribed by law and/or at the written request of the employee. LICH/EHS strictly observes this and all rules of medical ethics. However, THE LONG ISLAND COLLEGE EHS/OM will communicate to supervisory and Human Resources personnel on a need-to-know basis our assessment of the ability of an employee to mentally and physically perform his/her essential job functions without restrictions and without any immediate direct threat of harm to himself/herself or others.

ACCESS TO MEDICAL RECORDS: Under the Occupational Safety & Health Act (OSHA Standard 1910.20), employees have the right to see the LICH/EHS/OM medical record and exposure records maintained by LICH/EHS/OM , if any, related to potentially toxic substances or potentially harmful biological or physical agents. Forms are available in LICH/EHS/OM for the release of medical information, along with instructions on how the information requested can be secured.

**ALL VISITS TO LICH E.H.S REQUIRE I.D. A REFERRAL SLIP SIGNED BY THE EMPLOYEE'S SUPERVISOR.
 T. SAW 12/06**

Data Entered by _____ Date _____ **OVER**

INITIAL HEALTH ASSESSMENT QUESTIONNAIRE

(List on separate sheet if you need more space)

1. List all jobs you have held previously:
- a. _____ b. _____
 c. _____ d. _____
 e. _____ f. _____

2. Do you have any medical problem which might pose a potential risk to patients or co-workers, or which may interfere with the performance of your duties? YES NO **If yes, please describe:** _____

3. Have you ever had any serious accidents or injuries? YES NO
If yes, please list and indicate any that may have been work related:
- a. _____ work related? YES NO
 b. _____ work related? YES NO

4. Have you ever been hospitalized or out ill for any reason other than childbirth? YES NO
If yes, please list and indicate any possibly work related:
- a. _____ work related? YES NO
 b. _____ work related? YES NO

5. Have you ever had any surgical procedures done in the past? YES NO
yes explain _____

6. Have you filed any worker's compensation claims? YES NO
If yes, please explain _____

7. As travel to particular countries may increase your risk for certain diseases, please list the countries you have visited outside the continental US in the past year: _____

8. Please list all drugs or medications which you are taking now or have taken in the past twelve months: _____

a. Please list the medical conditions for which you take the medication: _____

9. Are you a smoker? YES NO Do you wish to quit smoking? YES NO
 Did you smoke previously? YES NO When did you quit _____

Do you have an addiction or habituation to alcohol, drugs or any other behavior altering substance that poses a potential risk to patients or co-workers or which may interfere with the performance of your job duties? YES NO

If you have answered "yes" please explain below and discuss with Employee Health Services clinician.

10. Do you have any known allergies to food, medications or other substances? YES NO
 Please check off any of the items below to which you have an allergy:
- Penicillin/ other medication: _____ Rubber Gloves
 Any Medicine Latex Skin Allergy
 Any Chemical Food Animals
 Other _____

continue on next page

Please describe the reactions you have to any of checked items(skin hives, trouble breathing, etc.)

11. In your job(s) or in your other activities have you ever come into direct contact with any of the following substances by breathing, touching or direct exposure? If you check off any of the following substances, please describe your contact in the space provided.

- | | | |
|-------------------|----------------|--|
| Asbestos | Formaldehyde | Solvents |
| Carbon Monoxide | Glutaraldehyde | Welding Fumes |
| Cleaning Products | Mercury | Other Potentially Harzardous Materials |
| Ethylene Oxide | Ribavirin | |

12. List all immunizations received and date of injections. Attach copies of medical records (unless performed in LICH EHS/OM).

Attach copies of any blood tests regarding immunization status for Rubella, Rubeola, Varicella, Mumps Diphtheria-Tetanus or Hepatitis B (unless performed in LICH EHS/OM). Attach copy of recent chest radiograph (X-Ray). List date taken and/or attach a copy of previous PPD/ testing record unless performed in LICH EHS/OM).

13. Please check off any of the following you have experienced in the past twelve months. If there are several choices, circle the one which applies to you:

	yes	no	unsure	new	have now	under medical care
General:						
a. High blood pressure/Diabetes						
b. Persistent fevers						
c. Night sweats						
d. Unplanned weight loss/gain over 10 lbs (circle which)						
e. Persistent change in energy						
Derm:						
f. Sores, lumps, skin rashes (circle which)						
Eyes:						
g. Eye discharge/ inflammation/ change in vision/ pain (circle which)						
Ears:						
h. Change in hearing						
Pulmonary:						
i. Frequent coughing with or w/o phlegm/ coughing up blood (circle which)						
j. Asthma, difficulty breathing, shortness of breath (circle)						
CVS:						
k. Angina, pain/pressure in the chest/ Palpitations (circle which)						
GI:						
l. Persistent diarrhea and/or abdominal pains (circle which)						
Musculoskeletal:						
m. Muscle/joint pain/ Frequent pain/ discomfort in lower back (circle which)						
Nervous System						
n. Persistent numbness or tingling in arms/legs (circle which)						
o. Unsteady walk/shaking (circle which)						
p. Fainting spells, severe dizziness, unexpected convulsions or seizures (circle which)						

Other(explain): _____

OVER

14. Will you be handling blood or blood products in your position at The Long Island College Hospital or with your employer? YES ___ NO ___
15. Have you previously received the Hepatitis B Vaccine? YES ___ NO ___
16. Do you want information on the Hepatitis B Vaccine? YES ___ NO ___

HEPATITIS B VACCINATIONS: If you have occupational exposure to any body fluids or other potentially infectious materials, you may be at risk of acquiring Hepatitis B Virus (HBV) infection. The Hepatitis B Vaccination series is available in LICH EHS/OM (without charge to LICH Employees). An appointment is necessary. If you belong to a risk category for Hepatitis B and elect not to be immunized for Hepatitis B, you must complete a Declination Form which will be kept on file in your medical record. If, at a future date you wish to receive the Hepatitis B Vaccine series, this Declination can be withdrawn.

THIS INITIAL AND SUBSEQUENT ANNUAL EVALUATION IS FOR THE PURPOSE OF DETERMINING YOUR PHYSICAL ABILITY TO PERFORM YOUR JOB AND WHETHER YOUR JOB MIGHT PRESENT A RISK. IT IS NOT TO BE CONSIDERED AS A SUBSTITUTE FOR A COMPLETE PHYSICAL/ REGULAR MEDICAL CARE BY YOUR PERSONAL PHYSICIAN.

ALL ANSWERS AND STATEMENTS PROVIDED BY ME ON THIS EXAMINATION FORM ARE COMPLETE AND TRUE. I UNDERSTAND AND AGREE THAT MY EMPLOYMENT DEPENDS UPON FULL DISCLOSURE OF ALL MEDICAL INFORMATION AND THAT MY FALSE OR MISLEADING STATEMENTS CAN LEAD TO MY IMMEDIATE DISMISSAL.

SIGNATURE OF EMPLOYEE: _____ **DATE SIGNED:** _____