



# Potomac Hospital

## Employee Health Record

Birth Date: \_\_\_\_\_ Department: \_\_\_\_\_  
 Work Status: \_\_\_\_\_ Employee Number: \_\_\_\_\_ Position: \_\_\_\_\_  
 Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Start Date: \_\_\_\_\_

Has any member of your immediate family (parents, spouse and or children) had any of the following? Circle yes or no and state relationship if "yes."

Tuberculosis	Yes	No	_____	High Blood Pressure	Yes	No	_____
Anemia	Yes	No	_____	Arthritis	Yes	No	_____
Diabetes	Yes	No	_____	Asthma/Hay Fever/Hives	Yes	No	_____
Cancer	Yes	No	_____	Epilepsy	Yes	No	_____
Kidney Disease	Yes	No	_____	Heart Disease	Yes	No	_____

Other not listed (describe) \_\_\_\_\_

Type of Immunization	**** IMMUNIZATIONS ****			Date of Last
Tetanus (Td)				
Rubella (German Measles)				
Rubeola (Red Measles)				
MMR (Measles, Mumps, Rubella)				
Varicella				
Polio				
Hepatitis B Vaccine	#1	#2	#3	Made by?
<b>Allergies (Please describe symptoms you experience)</b>				
Medication				
Food				
Environmental				
Latex Sensitivity or Allergy				

Illnesses you have had	Yes	No	Titer	Immunit y	Tuberculin Skin Test	
					Date(s)	Results
Chicken Pox						
Rubella (German Measles)						
Rubeola (Red Measles)						
Mumps						
Hepatitis B						
Other						

Have you ever had or do you now have any of the following? Give a date and explanation for each "yes" answer.

Condition	Yes	No	Condition	Yes	No
Rheumatic Fever			Swollen or painful joints		
Frequent or severe headaches			Dizziness or fainting spells		
Sinusitis			Asthma		
Shortness of breath			Pain or pressure in chest		
High blood pressure			Impaired hearing		
Painful or trick shoulder, elbow or knee			Recent gain or loss of weight		
Ear, nose or throat problems			Severe dental problems		
Goiter or thyroid problems			Tuberculosis		
Coughed up blood			Chronic Cough		
Night Sweats			Fevers of unknown cause		
Leg cramps			Varicose veins		
Foot trouble			Paralysis		
Epilepsy, fits or seizures			Back injury or strain		
Hernia (stomach or groin)			Rupture/herniated disk (back)		
Tumor, growth , cyst or cancer			Appendicitis		
Hemorrhoids (Piles) or rectal disease			Visual problems Contacts Glasses		
Frequent indigestion or intestinal problems			Jaundice		
Problems bending, lifting or reaching			Problems pushing or pulling		
Frequent or painful urination			Kidney stone or blood in urine		
Sugar or albumin in urine			Diabetes (sugar diabetes)		
Frequent boils, rashes or skin problems			Arthritis		
Venereal disease			Loss of arm, leg, finger or toe		
Loss of any paired organ (kidney, etc.)			Recurrent diarrhea or constipation		
Excessive bleeding after injury or tooth extraction			Anemia or low blood count		
Frequent trouble sleeping			Loss of memory		
Depression or excessive worry			Nervous problem or anxiety		
Drug alcohol or narcotic habit					
<b>Females Only</b>					
Are you pregnant?			Any recurrent, painful or irregular menstruation?		
Had any miscarriages?			Number of pregnancies		
Date of last menstrual period			Date of last pap smear		
<b>All Applicants</b>					
Dates: Last Physical: _____ Eye Exam: _____ Dental Exam: _____					
<b>Past Work History</b>					
Type of work	How long		Exposures to Chemicals, Radiation, Dust, Noise, Gases (name)		

Please Answer each question	Yes	No
Do you smoke? _____ Number of packs per day _____		
Do you drink alcoholic beverages? Amount _____ How often _____		
Have you been treated by clinics, physicians, healers or other practitioners within the last five years for any serious medical problems? If yes name:		
Are you presently under the care of a physician for any current medical problems? Explain:		
Have you had or been advised to have any operations? Describe and give dates:		
Have you had any serious illness or injury other than those already noted? Explain:		
Have you ever been a patient committed or voluntary to a mental hospital? Explain:		
Have you ever been denied life insurance? Explain:		
Have you ever been rejected from military service for physical, mental or other reasons? Explain:		
Have you ever been refused employment because of your health? Explain:		
Have you ever lost time from work as a result of an on-the-job accident while in the employ of another person or organization? Explain / Date(s)		
Have you received or have you applied for compensation for any existing disability?		
Have you been unable to hold a job because of:	-----	-----
a. Sensitivity to dust, chemicals, substances or sunlight?		
b. Inability to perform certain motions?		
c. Inability to assume certain positions?		
d. Other medical reasons: Explain:		

**Employee Health Nurse Notes:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications Taken Currently (daily or occasionally as needed)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Record of Physical Screening		
Temperature:	Height:	Ishihara: WNL Other:
Blood Pressure:	Weight:	Artificial Nails: Yes No
Pulse:	Hearing:	Other:

Record of Counseling and Testing			
Employee Health Program		Hepatitis B Vaccine	
- Hours		- Applicable	
- Availability / How to access		- Not applicable	
- Health Promotion		- Vaccine Completed	
- Routine Screenings		- Vaccine incomplete	
- Annual Screenings		- Vaccine Started at another facility	
- Stocked medications		- Refuses vaccination (sign declination)	
<b>Reporting Illnesses</b>		<b>Tests ordered or performed during screening</b>	
- When you are ill at work		- TST	
- When not to report to work		- Rubella / Rubeola / Mumps titer(s)	
<b>Potential for Blood Exposure</b>		- Varicella titer	
- None - Occasionally - Frequently		- Latex titer	
<b>Blood and Body Fluid Exposure Policy</b>		- Tetanus Booster given	
- Decontaminate immediately		- Hepatitis B Antibody titer	
- Report immediately (phone and EOR)		<b>Other Tests or procedures ordered</b>	
- Follow-up during and after hours		- Chest X-ray - Back Evaluation	

### Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself, however I decline to be vaccinated at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring hepatitis B, a serious disease. I understand that if I continue to have the same risk and change my mind about vaccination, I will be vaccinated at no charge to myself at that time.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I understand that this screening examination is designed to protect the patient from possible contagious or infectious disease and to evaluate by ability to perform the function of the position for which I am to be hired It is not considered to be a substitute for a regular physical examination by my private physician.

I also understand that there is a slight risk that at some time in my employment I may be exposed to a communicable disease, I therefore, realize the importance of consulting my private physician or the public health department for evaluation of immunization status, particularly in regard to pregnancy and or the desirability of rubella immunization.

I further understand that the release of any of this information to any organization or party shall be only with my written permission. I do, however, authorize the Employee Health Department to investigate all information learned in the course of this screening examination. I understand the omission or falsification of facts is cause for dismissal.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**