Your Hospital's Logo Here

INITIAL PRE-EMPLOYMENT EXAM

A comprehensive history is an important part of your medical record. Please complete this confidential questionnaire by placing a check mark in the appropriate spaces or by printing other information when required . (Use black or blue ink).

IDENTIFICATION

TODAY'S DATE:	LAST NAME:	FIRST (No nicknames)	MIDDLE
SEX: ☐ MALE ☐ FEMALE	SOCIAL SECURITY NO: - -		BIRTHDATE: - -
AGENCY / DEPT:	BLDG / ROOM		BUSINESS PHONE:
JOB TITLE:	SUPERVISOR		SUPERVISOR'S PHONE:
YOUR MAILING ADDRESS:	CITY / STATE	ZIP	HOME PHONE:

MEDICATIONS

List **ALL** medications (including prescription, vitamins, and herbal preparations) you currently take:

SOCIAL HISTORY:

(1) Have you ever used tobacco? ☐ YES ☐ NO

(a) If "YES", when? ☐ CURRENT ☐ PAST (Years since quitting?) ________

(b) If "YES", what type? ☐ CIGARETTES ☐ PIPE / CIGAR

________ Amount Per Day ________ For How Many Years

(2) What is your average alcohol consumption in a week? ________ Drinks (1 drink = 12 oz. Beer, 1 Glass Wine or 1.5 Oz. Liquor)

(3) How often do you drink alcohol? ☐ WEEKDAYS ☐ WEEKENDS ☐ BOTH

HOSPITALIZATIONS & SURGERIES

List **ALL** hospitalizations, surgeries, and the years they occurred:

LEISURE ACTIVITIES

(1) In which of the following hobbies / activities do you participate?

☐ Painting ☐ Auto / Boat Repair ☐ Ceramics / Pottery ☐ Guns / Hunting ☐ Other (Specify) ________

☐ Gardening ☐ Power Tool Usage ☐ Refinishing ☐ Stained Glass ________

(2) Do you use safety equipment when you engage in this activity? ☐ YES ☐ NO

HEARING QUESTIONNAIRE

Have you had prior military service? ☐ YES ☐ NO

Have you had previous ear surgery? ☐ YES ☐ NO

Have you had recurrent ear infections? ☐ YES ☐ NO

Do you have a known hearing loss? ☐ YES ☐ NO

Have you had noise exposure within the last 14 hours? ☐ YES ☐ NO

Do you wear hearing protection? ☐ YES ☐ NO

If "YES", what type? ☐ Foam ☐ Pre-Molds / Plugs ☐ Ear Muffins

RESPIRATOR QUESTIONNAIRE

Indicate the type of respirator you use: ☐ Cartridge ☐ Air Supply ☐ SCBA ☐ Filter / Mask

How often do you use a respirator? ☐ Daily ☐ 1x-4x per Week ☐ 1x-4x per Month ☐ 1x-4x per Year

Hours of use in a typical day: ☐ < 2 Hours ☐ 2-4 Hours ☐ 4-6 Hours ☐ > 6 Hours

Usual effort while wearing respirator? ☐ Light ☐ Moderate ☐ Heavy

Hazards present during respirator use: ☐ High Altitude ☐ Temperature Extremes ☐ Confined Spaces

Wear contact lenses? ☐ Y ☐ N

Previous respirator use? ☐ Y ☐ N

Difficulty with previous respirator use? ☐ Y ☐ N

Wear glasses? ☐ Y ☐ N

PAST MEDICAL HISTORY: Check any of the following conditions that you have now or have ever had:

Category	Condition	YES	NO
ABDOMEN	CHRONIC STOMACH PAIN	☐ YES	☐ NO
	DIARRHEA	☐ YES	☐ NO
	HEPATITIS	☐ YES	☐ NO
	HERNIA	☐ YES	☐ NO
	NAUSEA / VOMITING	☐ YES	☐ NO
	OTHER (Explain):		
BLOOD	ANEMIA	☐ YES	☐ NO
	BLEEDING DISORDER	☐ YES	☐ NO
BREATHING	ASTHMA	☐ YES	☐ NO
	SHORTNESS OF BREATH	☐ YES	☐ NO
	OTHER (Explain):		
CANCER	KNOWN (DIAGNOSED)	☐ YES	☐ NO
	SWOLLEN / TENDER NECK	☐ YES	☐ NO
EARS	DECREASED HEARING	☐ YES	☐ NO
	HEARING LOSS	☐ YES	☐ NO
	OTHER HEARING INJURY	☐ YES	☐ NO
	RINGING / BUZZING	☐ YES	☐ NO
	RUPTURED EAR DRUM	☐ YES	☐ NO
	OTHER (Explain):		
HEART	HEART ATTACK	☐ YES	☐ NO
	HEART MURMUR	☐ YES	☐ NO
	HIGH BLOOD PRESSURE	☐ YES	☐ NO
	IRREGULAR HEART BEAT	☐ YES	☐ NO
	STROKE	☐ YES	☐ NO
	CHEST PAIN / TIGHTNESS	☐ YES	☐ NO
	OTHER (Explain):		
INJURY	BROKEN BONES	☐ YES	☐ NO
	ELBOW	☐ YES	☐ NO
	FINGERS	☐ YES	☐ NO
	FOOT	☐ YES	☐ NO
	HAND	☐ YES	☐ NO
	HIP	☐ YES	☐ NO
	KNEE	☐ YES	☐ NO
	SHOULDER	☐ YES	☐ NO
	WRIST	☐ YES	☐ NO
	ANKLE	☐ YES	☐ NO
	OTHER (Explain):		
MENTAL	ANXIETY	☐ YES	☐ NO
	DEPRESSION	☐ YES	☐ NO
	MEMORY LOSS	☐ YES	☐ NO
	PHOBIAS	☐ YES	☐ NO
	OTHER (Explain):		
METABOLISM	DIABETES	☐ YES	☐ NO
	LOSS OF APPETITE	☐ YES	☐ NO
	THYROID DISORDER	☐ YES	☐ NO
	Unexplained WEIGHT GAIN / LOSS	☐ YES	☐ NO
	OTHER (Explain):		
MUSCOSKELETAL	ARTHRITIS	☐ YES	☐ NO
	BACK INJURY / PAIN	☐ YES	☐ NO
	BACK SURGERY	☐ YES	☐ NO
	HERNIATED DISK	☐ YES	☐ NO
	JOINT PAIN	☐ YES	☐ NO
	MUSCLE WEAKNESS	☐ YES	☐ NO
	OTHER (Explain):		
NECK	CHRONIC SORE THROATS	☐ YES	☐ NO
	DIFFICULTY SWALLOWING	☐ YES	☐ NO
	NECK INJURY	☐ YES	☐ NO
	SWOLLEN / TENDER NECK	☐ YES	☐ NO
	OTHER (Explain):		
NEURO	CONFUSION	☐ YES	☐ NO
	CONVULSIONS	☐ YES	☐ NO
	DECREASED ALERTNESS	☐ YES	☐ NO
	DIZZINESS	☐ YES	☐ NO
	FAINTING	☐ YES	☐ NO
	INJURY	☐ YES	☐ NO
	LOSS OF CONSCIOUSNESS	☐ YES	☐ NO
	MIGRAINES	☐ YES	☐ NO
	NUMBNESS / WEAKNESS	☐ YES	☐ NO
	TREMORS	☐ YES	☐ NO
	UNEXPLAINED SLEEPINESS	☐ YES	☐ NO
	CHRONIC HEADACHE	☐ YES	☐ NO
	OTHER (Explain):		
NOSE	CHRONIC NOSE BLEEDS	☐ YES	☐ NO
	SINUS DISORDERS	☐ YES	☐ NO
	OTHER (Explain):		
SKIN	JAUNDICE / YELLOWNESS	☐ YES	☐ NO
	RASH	☐ YES	☐ NO
	LATEX ALLERGY	☐ YES	☐ NO
	OTHER (Explain):		
URINE	BLADDER DISORDERS	☐ YES	☐ NO
	DARK URINE	☐ YES	☐ NO
	KIDNEY DISORDERS	☐ YES	☐ NO
	OTHER (Explain):		
VISION	COLOR VISION DISORDER	☐ YES	☐ NO
	CONTACTS	☐ YES	☐ NO
	DECREASED FAR VISION	☐ YES	☐ NO
	DECREASED NEAR VISION	☐ YES	☐ NO
	DOUBLE VISION	☐ YES	☐ NO
	GLASSES	☐ YES	☐ NO
	INJURY	☐ YES	☐ NO
	VISION IN ONE EYE ONLY	☐ YES	☐ NO
	BLURRED VISION	☐ YES	☐ NO
	OTHER (Explain):		
ANY OTHER			

EXAMINER'S COMMENTS (All positive responses above should be discussed here):

OCCUPATIONAL HISTORY

Briefly describe your current job's activities

How long have you been doing this type of work? ______ YRS

Have you ever been off work more than a day due to a work related illness / injury? ☐ YES (Specify) ☐ NO

Have you ever changed jobs or duties due to health problems? ☐ NO ☐ YES (Specify)

List **ALL** previous jobs:

Agency / Company	Employment Dates	Job Duties	Specific Hazards

NAME	SOCIAL SECURITY # - -	DATE:

EXPOSURE HISTORY

This section provides the examiner with information regarding your history of exposure to hazardous substances. Complete each item based on your personal experiences. When necessary, additional hazards may be added at the end of this insert.

Exposure Type	Frequency of Exposure				Length of Exposure	Symptoms from Exposure	Protection used with Exposure
Instructions Check chemicals or work conditions that apply to you	Often	Sometimes	Rarely	Seasonal	Instructions Usual # of hours exposed (hr./d)	Instructions List symptoms you feel may be associated with exposure	Instructions % time you wear protective equipment with this exposure i.e., 10%, 25%, 50%, etc.
DUSTS OR FUMES - Usual Route of Exposure: Inhalation							
1. Asbestos							
2. Cadmium							
3. Cement Dust							
4. Chromium							
5. Fiberglass							
6. Iron/Steel							
7. Lead							
8. Nickel							
9. Silica							
10. Welding Fumes							
11. Beryllium							
12. Aluminum							
13. Coal							
14. Other dust (Specify)							
SOLVENTS- Usual Route of Exposure: Inhalation and Skin							
15. Alcohol							
16. Formaldehyde							
17. Paints & Paint Thinners							
18. Degreasers (specify)							
19. Acids & Bases							
20. Epoxies							
21. PCBs							
22. Pesticides							
23. Wood Preservatives							
24. Other Chem. (Specify)							
OTHER POTENTIAL EXPOSURES OR WORK TASKS							
25. Blood/Body Fluids							
26. HazMat/Superfund Sites							
27. Noise > 85 dB							
28. Biological or chemical agents in military							
29. Other exposures (Specify)							

** **Often** = Almost Daily **Sometimes** = 1-3 times a month **Rarely** = less than monthly **Seasonally** = concentrated exposure during a predictable time period

EXAMINER'S COMMENTS (List exposure # with appropriate comment):

HEIGHT:	WEIGHT:	TEMP:	RESP:	BP:	PULSE:

DRUG ALLERGY:	GENERAL HEALTH / AFFECT:

VISION: ☐ GLASSES ☐ CONTACTS

	UNCORRECTED		CORRECTED		Peripheral VISION >>	HEARING	EKG	LABS	URINE DRUG SCREEN
	Right	Left	Right	Left	☐ NORMAL ☐ ABNORMAL	☐ NORMAL ☐ ABNORMAL	☐ DONE ☐ NOT NEEDED		
Near	20 /	20 /	20 /	20 /	Color VISION ☐ NORMAL	PFT >>	☐ DONE	☐ YES	☐ YES
Far	20 /	20 /	20 /	20 /	☐ ABNORMAL		☐ NOT NEEDED	☐ NO	☐ NO

	Normal	Abnormal	Not Done	Findings
Head/Neck	☐	☐	☐	
E.E.N.T.	☐	☐	☐	
Heart	☐	☐	☐	
Lungs	☐	☐	☐	
Abdomen	☐	☐	☐	
Muskuloskeletal	☐	☐	☐	
Extremities	☐	☐	☐	
Vascular-Pulses	☐	☐	☐	
Neurological	☐	☐	☐	
Skin	☐	☐	☐	
Lymphatics	☐	☐	☐	

ASSESSMENT / REFERRAL PLAN	COMMENTS	No Referral	REFERRED	
			ROUTINE	URGENT
(1) ______		☐	☐	☐
		☐	☐	☐
(2) ______		☐	☐	☐
		☐	☐	☐
(3) ______		☐	☐	☐
		☐	☐	☐
(4) ______		☐	☐	☐
		☐	☐	☐
(5) ______		☐	☐	☐

RECOMMENDATIONS / EDUCATION SUMMARY The following topics and recommendations marked with a ☐ were discussed with the employee.

☐ Protective Equipment

- ☐ Hearing
- ☐ Safety glasses
- ☐ Respirator use
- ☐ Gloves/Skin protection
- ☐ Seat belts
- ☐ DOT Clearance Required
- ☐ Other ___________________

- ☐ Smoking cessation
- ☐ Reduce or stop alcohol consumption
- ☐ Participate in regular cancer screening
- ☐ Self examiation (breast, testicular)
- ☐ Universal Precautions
- ☐ Avoid sun exposure/Use sun block
- ☐ Other ___________________

EXAMINER'S SIGNATURE:	EXAMINER'S PRINTED NAME:	DATE:
EXAMINER'S SIGNATURE:	EXAMINER'S PRINTED NAME:	DATE:

I GIVE MY CONSENT FOR A PHYSICAL EXAMINATION THAT MAY INCLUDE TESTS & PROCEDURES DEEMED NECESSARY

PATIENT SIGNATURE:	DATE: