Your Hospital's Logo Here

OCCUPATIONAL HEALTH SERVICES

Health Status Form

NAME (Last) :	NAME (First) :	NAME (MI) :

SOCIAL SECURITY NO:	DEPARTMENT:	TITLE:

EXTENSION:	SEX: ☐ F ☐ M	RACE:	DATE OF BIRTH:	DATE OF HIRE:

SIGNIFICANT MEDICAL / SURGICAL HISTORY	MEDICATIONS

ALLERGIES	MEDICATIONS	FOOD	LATEX	ENVIRONMENTAL

OCCUPATIONAL INJURY / ILLNESS HISTORY

DATE	DESCRIPTION	OUTCOME

IMMUNIZAT'NS	DATES	IMMUNE	+	-	COMMENTS
Hepatitis "B"					
Rubeola					
Rubella					
Mumps					
Varicella					
T d					
Influenza					
Smallpox					

T B Status: ☐ NEG ☐ POS CXR Date (s): _____

Prophylaxis Date: _____ Medications: _____