CONWAY REGIONAL HEALTH SYSTEM

CONFIDENTIAL MEDICAL HISTORY

EMPLOYEE HEALTH

NAME _____ SS# _____ DOB _____

ADDRESS _____ PHONE _____

EMERGENCY CONTACT _____

NAME RELATIONSHIP PHONE

DEPARTMENT _____ POSITION _____

Do you have or have you ever had any of the following:

☐ Head or Brain Injury	☐ Angina	☐ Neck injury
☐ Frequent headaches or dizziness	☐ Heart palpitations	☐ Arthritis
☐ Seizures	☐ Rheumatic fever	☐ Skin rash/Eczema
☐ Poor hearing	☐ Swollen/painful joints	☐ Varicose Veins
☐ Wear hearing device	☐ Chicken pox	☐ Kidney/ Bladder problems
☐ Blurred vision	☐ Thyroid disorder	☐ Prostates disease
☐ Glasses/contacts	☐ Ulcers	☐ Cancer
☐ Fainting spells	☐ Heartburn	☐ Blood in sputum, urine or stool
☐ Asthma	☐ Bowel disorder	☐ Depression/anxiety
☐ COPD	☐ Hepatitis	☐ Alcohol/drug use
☐ Chronic cough	☐ HIV positive	☐ Carpal tunnel
☐ Tuberculosis	☐ Hernia	☐ Problems with legs ankles or feet
☐ High Blood Pressure	☐ Back injury	☐ Test for Tuberculosis in the last year (PPD)

Have you ever been hospitalized?	❑ Yes	❑ NO
Have you been seriously injured?	❑ Yes	❑ NO
Are you allergic to Latex?	❑ Yes	❑ NO
Have you ever had surgery?	❑ Yes	❑ NO
Do you have any known allergies?	❑ Yes	❑ NO
Have you ever received workers compensation benefits before?	❑ Yes	❑ NO

If you answered yes to any of the above questions please explain: _____

Do you feel you are able to meet the physical requirements that your job would require? If no, please explain:

CONWAY REGIONAL HEALTH SYSTEM

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

EMPLOYEE HEALTH

NAME: _____ DATE: _____

Sex _____ Date of Birth: _____ Height ___ft ___in Weight _____

Pregnant: Yes NO Department _____ Job Title _____

Have you ever worn a respirator before? Yes NO If Yes, What type? _____

Limitations (Check one): ☐ None ☐ Beard ☐ Glasses ☐ Dentures

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes NO
   Pack history: _____

2. Have you ever had any of the following conditions? (check if yes)
   - ☐ Seizures
   - ☐ Diabetes
   - ☐ Allergic reactions that interfere with your breathing
   - ☐ Claustrophobia (fear of closed in spaces)
   - ☐ Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems? (check if yes)
   - ☐ Asbestosis
   - ☐ Asthma
   - ☐ Chronic bronchitis
   - ☐ Emphysema
   - ☐ Pneumonia
   - ☐ Tuberculosis
   - ☐ Silicosis
   - ☐ Pneumothorax (collapsed lung)
   - ☐ Lung cancer
   - ☐ Broken ribs
   - ☐ Any chest injury or surgeries
   - ☐ Any other lung problem that you have been told about

4. Do you have any of the following symptoms of pulmonary or lung illnesses? (check if yes)
   - ☐ Shortness of breath
   - ☐ Shortness of breath when walking fast on level ground or walking slightly up hill
   - ☐ Shortness of breath when walking with other people at an ordinary pace on level ground
   - ☐ Have to stop for breath when walking at your own pace on level ground
   - ☐ Shortness of breath when washing or dressing your self
   - ☐ Shortness of breath that interferes with your job
   - ☐ Coughing that produces phlegm (thick sputum)
   - ☐ Coughing that wakes you up early in the morning
   - ☐ Coughing that occurs mostly when you are lying down
   - ☐ Coughing up blood in the last month
   - ☐ Wheezing
   - ☐ Wheezing that interferes with your job
   - ☐ Chest pain when you breathe deeply
   - ☐ Any other symptom that you think might be related to lung problems

CONWAY REGIONAL HEALTH SYSTEM

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

EMPLOYEE HEALTH

5. Have you ever had any of the following cardiovascular or heart problems? (check if yes)
   - ☐ Heart attack
   - ☐ Stroke
   - ☐ Angina
   - ☐ Heart failure
   - ☐ Swelling in your legs or feet (not caused by walking)
   - ☐ Heart arrhythmia (heart beating irregularly)
   - ☐ High blood pressure
   - ☐ Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms? (check if yes)
   - ☐ Frequent pain or tightness in your chest
   - ☐ Pain or tightness in your chest during physical activity
   - ☐ Pain or tightness in your chest that interferes with your job
   - ☐ In the past two years, have you noticed your heart skipping or missing a beat
   - ☐ Heartburn or indigestion that is not related to eating
   - ☐ Any other problems that you think might be related to heart or circulation problems

7. Do you currently take any medications for any of the following problems? (check if yes)
   - ☐ Breathing or lung problems
   - ☐ Skin allergies or rashes
   - ☐ Anxiety
   - ☐ General weakness or fatigue
   - ☐ Any other problem that interferes with your use of a respirator

8. If you have used a respirator, have you had any of the following problems? (check if yes)
   - ☐ Eye irritation
   - ☐ Skin allergies or rashes
   - ☐ Anxiety
   - ☐ General weakness or fatigue
   - ☐ Any other problems that interferes with your use of a respirator

9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers? Yes NO

Employee Signature: _____ DATE: _____

Approval Signature: _____ DATE: _____

Mask Size: Regular Small

Yes NO Satisfactory Qualitative Bitrex Fit Test	Yes NO Donning & Removing Mask
Yes NO Satisfactory Positive/Negative Pressure Fit Check Test	Yes NO Location of Masks for use when needed
Number of Sensitivity Sprays <5 <10 <15	Number of Fit Test Sprays 5 10 15

CONWAY REGIONAL HEALTH SYSTEM

HEPATITIS B VACCINE

EMPLOYEE HEALTH

Please check the option below that is appropriate:

I have already completed the series, therefore I decline it.

I wish to decline the vaccine.

I am interested in taking the vaccine.

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

CONWAY REGIONAL HEALTH SYSTEM

ANNUAL TUBERCULOSIS SCREENING

EMPLOYEE HEALTH

NAME _____ EMP# _____ DOB _____

DEPARTMENT _____ DATE _____

Tuberculosis Screening

Have you ever had a TB skin test?	❑ Yes	❑ NO
Have you ever had a reaction to a TB skin test?	❑ Yes	❑ NO
Is there a history of Tuberculosis in your family?	❑ Yes	❑ NO
Have you ever taken a medication for Tuberculosis?	❑ Yes	❑ NO
Have you ever had a vaccine called BCG?	❑ Yes	❑ NO
Have you had a MMR or Varicella vaccination in the last 3 months?	❑ Yes	❑ NO
Have you been treated with steroids in the past month?	❑ Yes	❑ NO
Do you have an immune compromised illness?	❑ Yes	❑ NO
Are you pregnant?	❑ Yes	❑ NO
Were you born in a Country where tuberculosis is common?	❑ Yes	❑ NO
Have you traveled outside of the US in the last 12 months?	❑ Yes	❑ NO
Have you ever or do you currently live in a large group setting? (examples: homeless shelter or correctional facility)	❑ Yes	❑ NO

Do you currently have any of the following symptoms?

Unusual fatigue for more than 2 weeks	❑ Yes	❑ NO
Weight loss (unrelated to dieting)	❑ Yes	❑ NO
Loss of appetite for more than 2 weeks	❑ Yes	❑ NO
Persistent cough longer than 2 weeks	❑ Yes	❑ NO
Fever associated with cough for more than 1 week	❑ Yes	❑ NO
Night sweats unrelated to hormone imbalance	❑ Yes	❑ NO