Marshfield Clinic
HEALTH SYSTEM

POST-OFFER HEALTH EVALUATION / ASSESSMENT

This form is intended to be used by medical and nursing personnel only and will be kept separate from your personnel file.

Name:		Date of birth:		Phone:			
Address:		City:		State:		Zip:	
E-mail Address:		Position Accepted:					
Department:		Facility:					
In emergency notify:		Relationship:		Phone:			
Address:		City:		State:		Zip:	

This form is to assist Employee Health staff to assess your ability to perform the core duties of the job for which you have applied, determine whether accommodations are appropriate or required, and provide a reference source involving relevant medical history. Some job classifications may require additional information and examinations. Subsequent to the certification statement on the bottom of page 2, this form will be treated as a **CONFIDENTIAL** document in your Employee Health Record. In answering questions on this form, you should not include genetic information. This is, please do not include any family medical history or any info0rmation relating to genetic testing, genetic services, genetic counseling or genetic diseases for which you believe you may be at risk.

I have reviewed the job description and physical requirements of the position I have accepted and can perform all essential functions

_____ without reasonable accommodations

_____ with reasonable accommodations. Define needs: _____

Please check one and initial here: _____

If you have had labs drawn for Measles (Rubeola), Mumps, Rubella, Chicken Pox titers or Hepatitis B antibodies, bring a copy of the results with you to your scheduled assessment. Also, bring immunization records if available.

When was your last Td / Tdap (circle one) Date: _____

If you have had a TB skin test in the past, when and where was it done:

Last TB skin test date: _____ Result: _____ Facility: _____

Have you ever had the BCG Vaccine? ☐ No ☐ Yes _____

Have you had any vaccines in the last 6 weeks? ☐ No ☐ Yes

When was your last Influenza vaccine? Date: _____

MEDICAL HISTORY (please check all that apply):

- ☐ Dizziness / Fainting
- ☐ Ear Infections
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Eye Infections
- ☐ Failing Vision
- ☐ Glasses / Contact Lens
- ☐ Color Blindness
- ☐ Hay Fever / Allergies
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Asthma / Wheezing
- ☐ Bronchitis / Chronic Cough
- ☐ Shortness of breath
- ☐ Pneumonia
- ☐ Sore Throat
- ☐ Thyroid Disease
- ☐ Difficult Swallowing
- ☐ Abdominal Pain / Chronic /Hernia
- ☐ Gallbladder Trouble
- ☐ Indigestion or Heartburn
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Blood in Urine
- ☐ Frequent/Painful Urination
- ☐ Difficulty Urinating / Dribbling
- ☐ Kidney Stones
- ☐ Loss of Bladder Control
- ☐ Urinary Infections / Frequent
- ☐ Venereal Disease
- ☐ Loss of Appetite
- ☐ Peptic Ulcers
- ☐ Persistent Nausea
- ☐ Vomiting
- ☐ Jaundice / Hepatitis
- ☐ Bloody or Black Stools
- ☐ Change in Bowel Habits
- ☐ Constipation / Diarrhea
- ☐ Crohn's/Colitis/Diverticulitis
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome
- ☐ Chest Pain
- ☐ Coronary Artery Disease
- ☐ Heart Murmur
- ☐ High / Low Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Stroke
- ☐ Tremor / Hands Shaking
- ☐ Depression / Anxiety
- ☐ Nervousness / Panic
- ☐ Sleep Disorder / Apnea
- ☐ Drug / Alcohol Abuse
- ☐ Psoriasis / Eczema
- ☐ Rashes / Hives
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Fibromyalgia
- ☐ Myofascial Pain Syndrome
- ☐ Diabetes
- ☐ Convulsions / Seizures
- ☐ Numbness / Tingling Sensation
- ☐ Lupus
- ☐ RSD (Reflex Sympathetic Dystrophy)
- ☐ Anemia / Bruise Easily
- ☐ Arthritis / Bursitis / Tendonitis
- ☐ Back Pain-Chronic/Recurrent / Injury
- ☐ Carpal Tunnel Syndrome
- ☐ Elbow / Shoulder / Wrist Problem
- ☐ Foot/Ankle / Knee Problem
- ☐ Gout
- ☐ Fractures / Broken Bones
- ☐ Leg Pain / Walking
- ☐ Muscle ~~Disease~~ pain
- ☐ Headaches – Frequent
- ☐ Migraines
- ☐ Neck Pain – Chronic/Recurrent
- ☐ TMJ (Temporomandibular Joint)
- ☐ Osteoporosis (Brittle Bones)
- ☐ Swollen Ankles
- ☐ Permanent Disability
- ☐ Tobacco Use: Smoking/Chewing
- ☐ Unexplained Weight Change
- ☐ Surgically / Accidentally Implanted Metal Objects / Devices

Other (include surgeries):

_____

_____

_____

Name: _____ DOB: _____

1. Briefly explain any items checked in the Medical History section:
   _____

2. List any medications you are taking:
   _____

HEALTH BEHAVIORS:

Have you seen a health provider in the last year? No ___ Yes ___ Explain: _____
Do you perform self-breast or testicular examinations? No _____ Yes _____
Do you consume caffeine? No _____ Yes _____ If yes, amount per day _____
Do you use or have you used tobacco?
No _____ Yes _____ Amount per day _____ Age when started _____ Age when stopped _____
Do you drink alcohol or use other types of drugs? No _____ Yes _____ Amount per week _____
Do you eat something from the following food groups every day? (Meat, Dairy Products, Grains/Cereal, Fruits and Vegetables) No ____ Yes ____
Do you exercise or participate in some type of physical activity?
No _____ Yes _____ Type(s) of Activity(s) _____
Do you have hobbies?
No _____ Yes _____ Type(s) of Activity(s) _____

OCCUPATIONAL HISTORY:

A. Have you ever had an allergic reaction, and/or sensitivity to any drugs, food(s), plants, or chemicals? ☐ No ☐ Yes
   If **YES**, specify substance and reaction:
   _____
   _____

B. Have you ever had contact with any substance or items that caused a reaction (i.e., latex gloves, medical devices, personal items – balloons, condoms, band-aids, adhesive tapes, clothing - the elastic or stretch fabric, bananas, avocados, kiwi)?
   ☐ No ☐ Yes (explain) _____
   _____
   _____

C. Have you ever worked with any of the following:

	No	Yes		No	Yes
* Antineoplastic/Cytotoxic Drugs	☐	☐	* Excessive Noise	☐	☐
* Asbestos/Silicosis	☐	☐	* Dust	☐	☐
* Formaldehyde	☐	☐	* Latex	☐	☐
* Ethylene	☐	☐	* Lasers	☐	☐
* Lead / Mercury	☐	☐	* Pesticides	☐	☐
* Radiation	☐	☐	* Gluteraldehyde	☐	☐
* Anesthetic Gases	☐	☐	* Blood or body Fluids	☐	☐

   * Any Other Substances – Specify: _____

D. Have you ever been injured at work? ☐ No ☐ Yes
   Date(s) of injury/illness: _____
   Description of injury/illness: _____
   _____
   Lost / restricted days: ☐ No ☐ Yes Explain: _____
   _____

E. Have you ever had lost or restricted work days due to a **non work-related** illness or injury? ☐ No ☐ Yes (explain) _____
   _____

I certify that the facts set forth in this Post-Offer Health History are true and complete and I authorize investigation of the statements I have made. I understand that any false statements or omissions concerning requested information on this form shall be sufficient cause for denial of employment or summary dismissal. I also understand that this will become part of my Employee Health Record.

_____ _____
Signature Date