Department of Occupational & Environmental Medicine
Yawkey Ambulatory Care Center (1st Fl YACC1)
850 Harrison Avenue
Boston, MA 02118-2393
P: 617-638-8400 F: 617-638--8406

Pre-placement Questionnaire

Name	Date of Birth	Gender	Date
Phone Number (Cell/Home)	**Email**	**Position Applied For**	**Department**
Hiring Manager	**Start Date**	**List Previous Occupations**	

Exposures – Occupational/Recreational (include animal, chemical, heavy metal (e.g. mercury), or fibers (e.g. asbestos)	Medications and Supplements (Please list prescribed and over the counter items whether taken daily or as needed)
Allergies (include medication allergy or reactions, animals, foods, season/environmental/chemical, latex, etc.)	

PAST/CURRENT MEDICAL HISTORY (Please explain yes answers below with number)

	CHECK EACH ITEM	YES	NO		CHECK EACH ITEM	YES	NO		CHECK EACH ITEM	YES	NO
1	Anemia or other blood disorders	☐	☐	21	High or low blood pressure	☐	☐	41	Back/neck problems or recurrent injuries	☐	☐
2	Bleeding disorders or bruise easily	☐	☐	22	Palpitation or pounding heart	☐	☐	42	Broken bones	☐	☐
3	Rashes, eczema or other skin problems	☐	☐	23	Pain or pressure in chest	☐	☐	43	Muscle problems	☐	☐
4	Head injury/concussion	☐	☐	24	Rheumatic or scarlet fever	☐	☐	44	Balance or coordination problems	☐	☐
5	Stroke, aneurysm or bleeding in brain	☐	☐	25	Abnormal EKG	☐	☐	45	Fibromyalgia or chronic fatigue syndrome	☐	☐
6	Dizziness or fainting spells	☐	☐	26	Frequent cramps in your legs	☐	☐	46	CT, MRI scan or other special tests	☐	☐
7	Frequent or severe headaches	☐	☐	27	Phlebitis or varicose veins	☐	☐	47	Paralysis	☐	☐
8	Epilepsy or seizure	☐	☐	28	Stomach or intestinal problems	☐	☐	48	Unconsciousness for any reason	☐	☐
9	Loss of memory or amnesia	☐	☐	29	Hernia	☐	☐	49	Current drugs or substance dependence or abuse	☐	☐
10	Eye or vision problems	☐	☐	30	Jaundice or hepatitis/liver disease	☐	☐	50	Frequent trouble sleeping	☐	☐
11	Color vision difficulty	☐	☐	31	Pancreatic/spleen disease	☐	☐	51	Sleep apnea	☐	☐
12	Wear corrective lenses/glasses	☐	☐	32	Kidney/bladder problems	☐	☐	52	Asthma/wheezing	☐	☐
13	Hearing loss or hearing aid use	☐	☐	33	Arthritis, Rheumatism, joint pain or swelling	☐	☐	53	Chronic cough	☐	☐
14	Other ear problems	☐	☐	34	Dislocation of any joint	☐	☐	54	Frequent colds or lung infections	☐	☐
15	Frequent rhinitis or sinusitis	☐	☐	35	Hand/wrist problems or any difficulty grasping	☐	☐	55	Shortness of breath	☐	☐
16	Speech problems	☐	☐	36	Carpal tunnel	☐	☐	56	Tuberculosis or positive TB test	☐	☐
17	Thyroid problems	☐	☐	37	Numbness or tingling in fingers or toes or other nerve problems	☐	☐	57	Surgeries	☐	☐
18	Diabetes or blood sugar problems	☐	☐	38	Shoulder/elbow problems or recurrent injuries	☐	☐	58	Other health problems not mentioned above	☐	☐
19	Tumor, growth, cyst or cancer	☐	☐	39	Hip/knee problems or recurrent injuries	☐	☐				
20	Problems related to the heart	☐	☐	40	Foot/ankle problems or recurrent injuries	☐	☐				

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NAME: _____	**DATE OF BIRTH:** _____
"YES" Answers to Past/Current Medical History (please place corresponding number from above with comments; use back of page or attach sheet if more space is required)	

CHECK EACH ITEM
(Please explain yes answers in the area to the right)

ITEM	YES	NO	Explanation: _____
Have you ever been told to restrict your physical activity at work?	☐	☐	
Is there any equipment that is necessary to help you best perform your job activities (e.g. phone headset, special chair, etc.)?	☐	☐	
Do you have any health condition(s) that may interfere with your ability to perform your basic job duties in a healthy and safe manner?	☐	☐	

Please check below if you may be working with the following:
☐ Blood/Bodily Fluids ☐ Lasers ☐Research Animals ☐ Chemicals ☐ Radiation ☐Other (Please list):

DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING (CHECK ANY THAT APPLY): ☐ prolonged sitting ☐ prolonged standing ☐ prolonged walking ☐ reaching above shoulder level ☐ lifting over 45 pounds ☐ carrying over 35 pounds ☐ forceful push ☐ forceful pull

DO YOU HAVE ANY DIFFICULTY USING THE FOLLOWING (CHECK ANY THAT APPLY):
☐ Gloves (specify types) ☐ Respirator (specify types) ☐Tyvex overalls ☐Hearing protection (ear plugs/ muffs)

By signing below, I signify that the above answers are true and accurate to the best of my knowledge:
SIGNATURE OF APPLICANT: DATE SIGNED:

Physical Date (OEM Staff Only)

Height: _____	Weight: _____	Blood Pressure: _____	Pulse: _____	BMI: _____
Visual Acuity	Without corrective lenses		With corrective lenses	
Far Vision	Right 20/_____ Left 20/_____ Both20/_____		Right 20/_____ Left 20/_____ Both20/_____	
Near Vision	Right 20/_____ Left 20/_____ Both20/_____		Right 20/_____ Left 20/_____ Both20/_____	
Visual Fields	Right _____ degrees		Left _____ degrees	
Color Vision	Ishihara: Normal _____	Abnormal: _____	Yarn Test: ☐ Pass ☐Fail	
Hearing	Whisper at 6 feet: ☐ Pass ☐ Fail		Spoken voice 4 feet: ☐ Pass ☐ Fail	