SARATOGA HOSPITAL
people you trust. care you deserve.

PRE-PLACEMENT MEDICAL HISTORY FORM

Attached is your pre-placement medical work history form. Please complete this form prior to coming for your exam. To expedite your evaluation, please provide any records of immunizations from your physician. If you have had a skin test for tuberculosis within the last year, please bring a copy of the results with you. The purpose of this evaluation is to determine whether you are medically able to perform the duties for the position that has been offered you. The information will not be released to any unauthorized people. Please complete this form with **pen/ink**.

If you have any questions or need to change your appointment, please contact the Employee Health Office at 583-8487.

Please bring the following with you to your appointment.

- Completed Pre-Placement History Form
- Photo ID
- Hepatitis B Vaccine dates and proof of titer
- Proof of last Tuberculosis Skin Test (PPD, Mantoux). If positive, copy of last chest x-ray results and treatment plan.
- Proof of Tetanus Booster (TD) or Tdap
- Proof of two Measles / Mumps / Rubella Vaccine (MMR) or Titers
- Proof of Varicella vaccine or immune titer result
- Proof of Influenza vaccine

NYS regulations require all persons who work in healthcare facilities to be immune to measles and rubella. If you do not have proof of vaccination, we will determine if a vaccine is indicated and administer that to you upon employment.

Name: _____ Social Security Number: _____-_____-_____

Street Address: _____ City: _____ State_____ Zip_____

Phone: _____ Date of Birth: _____ Sex: _____

Job Title_____ Department_____

Notify in Emergency: _____ Relationship: _____ Phone: _____

Personal Physician: _____ Address: _____ Phone: _____

I certify that I have reviewed the forgoing information supplied by me and that it is true and complete to the best of my knowledge. **If a subsequent investigation proves that any of the statements made by me herein are false, I understand that such misrepresentation is cause for dismissal.** Further, I understand the following:

1. That an offer of employment has been made prior to this medical exam. The results of this medical evaluation, lab tests, and/or additional diagnostic tests ordered are used to determine if I can perform the essential functions of the job.
2. That I may be required to provide additional medical information and/or undergo further medical evaluation to properly complete the assessment.
3. That to the extent that I have identified myself as an individual formally addicted to drugs has undergone successful treatment and rehabilitation. I may be required to produce evidence that I am participating and / or have successfully participated in a full course of treatment.
4. That the hospital has an established substance abuse and testing policy pursuant to which for cause as determined by the hospital. I may be required to submit to blood, saliva, hair and / or urine sample for testing.

Signature: _____ Date: _____

HEALTH HISTORY

Circle "Y" for YES and "N" for NO for the following questions:

			If you answered YES, please list:
Y	N	Have you ever been hospitalized?	Reason:
Y	N	Have you been under a doctor's care in the past year?	Reason:
Y	N	Do you exercise regularly?	[redacted]
Y	N	Are you in good health now?	
Y	N	Are you taking prescribed medicines?	If yes, please list:

ALLERGIES

			If you answered YES, please list:
Y	N	Are you allergic to any medicines?	
Y	N	Are you allergic to environmental allergens?	
Y	N	Have you ever been told by a doctor that you have an allergy to any latex product?	Did you have a RAST test? Y N
Y	N	Do you smoke? No. cigarettes/day_____ If quit, when?	[redacted]
Y	N	Are you on a special diet?	

SURGERIES/MEDICAL

			If you answered YES, please list
Y	N	Have you had major or minor surgery?	
Y	N	Have you ever been treated for a psychiatric disorder?	Reason:
Y	N	Have you ever been treated for substance abuse?	When:
Y	N	Have you traveled outside the U.S. in the past two weeks?	List countries:
Y	N	Do you drink alcohol?	No. drinks/week
Y	N	Do you drink coffee?	No. cups/day

OCCUPATIONAL HISTORY

			If you answered YES, please list
Y	N	Do you have any medical disorder or impairment which would interfere in any way with the full performance of your duties.	
Y	N	Have you reviewed the Physical Demand Analysis for your position?	[redacted]
Y	N	Do you believe that you will need any accommodation, because of a medical/disability condition to perform your job?	
Y	N	Are you unable to work a full day without discomfort?	
Y	N	Have you ever left or been refused a job for health reasons?	Reason:
Y	N	Have you ever had a Workers' Compensation injury and medical treatment for it?	Reason and Dates:
Y	N	Have you ever been awarded permanent disability/scheduled loss of use for a Workers' Compensation injury?	Reason and Dates:
Y	N	Do you have any hobbies?	

REVIEW OF SYSTEMS

Circle "Y" for YES if you have ever had any of the following problems and "N" for NO if you have not:

Y	N	Chronic fatigue	Y	N	Cold sores or fever blisters
Y	N	Rheumatic fever	Y	N	Cancer
Y	N	Stroke	Y	N	Trouble concentrating or remembering
Y	N	High or low blood pressure	Y	N	Blood, protein or sugar in urine
Y	N	Pneumonia, pleurisy, bronchitis	Y	N	Recent loss or gain of weight
Y	N	Tuberculosis Date_____ Rx._____	Y	N	Disease of penis, testicles or prostate gland
Y	N	Asthma, emphysema	Y	N	Disease of ovaries, uterus or breasts
Y	N	Night sweats	Y	N	Are you now pregnant?
Y	N	Chronic coughs, hoarseness, wheezing	Y	N	Anemia, easy bleeding or bruising
Y	N	Ear, nose, sinus, or throat trouble	Y	N	Blood or lymph node trouble
Y	N	Hearing loss	Y	N	Hay fever, hives
Y	N	Shortness of breath, chest tightness	Y	N	Skin trouble or allergies
Y	N	Pain, pressure or pounding in chest	Y	N	Knee, neck or shoulder problems
Y	N	Swelling of ankles	Y	N	Back trouble, herniated disc, sciatica
Y	N	Heart murmur, mitral valve prolapsed	Y	N	Locking, dislocated or weak joints
Y	N	Varicose veins, leg pain, cramps, clots	Y	N	Other bone, joint injury
Y	N	Heart disease, Heart attack Last EKG _____	Y	N	Carpal Tunnel, tendonitis, bursitis
Y	N	High cholesterol / triglycerides	Y	N	Broken or fractured bone
Y	N	Diabetes	Y	N	Paralysis, tingling, muscle weakness, numbness
Y	N	Thyroid or other gland trouble	Y	N	Eye trouble, contact lenses Last exam date: _____
Y	N	Stomach, gallbladder trouble	Y	N	Chronic or severe headaches or dizziness
Y	N	Intestinal trouble	Y	N	Fainting spells, seizures or head injury
Y	N	Diarrhea, dysentery, typhoid fever	Y	N	Drug or narcotic use
Y	N	Kidney or bladder trouble, kidney stone	Y	N	Nervous trouble, depression, trouble sleeping
Y	N	Hernia	Y	N	Alcohol-related problems
Y	N	Rheumatism, arthritis, gout	Y	N	Jaundice, hepatitis

Do you have any other health conditions not mentioned? Y or N

Please list: _____

Examiner's comments summary or elaboration of pertinent data:

Examiner's Signature: _____ Date: _____

Revised Jan 2014