HOSPITAL FOR SPECIAL SURGERY

Occupational Health Services
Health History

Date: _____

Name: _____ D.O.B_____ Cell Phone #_____
Home Address: _____Email Address: _____
Current Health Care Provider: _____
Address: _____ Phone Number: _____

Family Health:
Current state of health: alive or deceased, and current health conditions.
Mother: _____
Father: _____

Allergies: □ No □ Yes If yes, describe reaction:

- □ Food _____
- □ Drug _____
- □ Environmental _____
- □ Latex _____
- □ Other _____

List all **current medications** including prescriptions, birth control pills, non prescription, and dietary supplements: _____

Have there been any **changes in your health in the past 12 months**? If yes, explain:
_____

Have you ever been **hospitalized for any condition**? Yes___ No___ Explain:
_____

Social History:
Have you ever smoked **cigarettes/other substances** ? YES ___ NO ___
How long did you smoke? _____ How much? _____
How much **alcohol** do you consume per week? _____
Do you use illicit/illegal drugs? YES ___ NO ___
If yes, what kind: _____
Were you ever treated for **drug/alcohol addiction**? If yes, describe:
_____

Do you have any body piercing? YES ___ NO ___ Do you use **seat belt**s? YES ___ NO ___
Do you have any tattoos? YES ___ NO ___ Do you use **sun block**? YES ___ NO ___

Are you in a relationship or situation with someone who is physically or psychologically abusive? Or threatens to hurt you? _____
Does anyone control most of your daily activities? For instance do they tell you who you can be friends with or how much money you can take when you go shopping Yes ___ No ___

Name_____

Occupational History:
Have you ever had a splash or **Blood Borne Pathogen Exposure**? **Yes __ No __**
Date: _____ did you have **BBPE follow up**? **Yes __ No __**
If your job involves work at a computer, have you had or are you experiencing any discomfort, pain, or numbness when working at your desk? **Yes ___ No___**
Have you ever had an occupational injury/illness before (e.g., back strain, chemical? Exposure)? **Yes ___ No ___If Yes, describe_____**

Work History:
Date last worked: _____ Where? _____
Medical discharge from military? **Yes ___ No ___**
Have you ever been exposed/worked around to hazardous/toxic chemicals/conditions? If yes, explain:
_____

In completing this questionnaire on my health history, I certify that the above information is true and correct to the best of my knowledge. I agree to all tests including labs, chest x-ray, and/or immunizations which are required /recommended by the N.Y State Department of Health.

Check all that apply: If checked, explain in detail

__ Anorexia	__ Depression/Anxiety	__ Hepatitis A, B, C
__ Asthma	__ Headaches	__ Irregular Heart Beat
__ Bleeding Disorder	__ Heart Attack	__ Pacemaker
__ Blood Clot	__ Hearing Aid	__ Prosthesis
__ Chest Pain	__ Hearing Loss	__ Psychiatric Disorder
__ Chicken Pox	__ High Blood Pressure	__ Thoughts of harming self or others
__ Coronary Artery Disease	__ Diabetes	__ Thyroid Disease
__ Weight Loss/Gain		

If checked, explain in detail:
_____
_____
Have you ever tested positive for a **Tuberculin Skin Test (TST)?** Yes___ No ___
If tested positive, what year____? Were you treated? Yes ___ No ___Chest x-ray Date___Results__
If yes, what medication were you treated with? _____How long? _____

Employee/Volunteer Signature: _____ **Date: _____**

Review of Systems: _____
_____
_____
_____
_____

Healthcare Provider Signature: _____ **Date**: _____
□ OHS NP □ OHS MD □ PCP □ OHS RN

PLEASE SUBMIT IMMUNIZATION RECORDS AND BLOOD TITER RESULTS FOR MEASLES, MUMPS, RUBELLA, VARICELLA, HEPATITIS B ANTIBODY AND HEPATITS B ANTIGEN Revised 02/11/14

HOSPITAL FOR SPECIAL SURGERY

Occupational Health Services
Pre-Employment Physical

Name: _____ D.O.B_____

Height:_____ Weight:_____
BP_____ Pulse:_____
BMI:_____
Hearing: Whisper R____L__

Vision:
Left Eye 20/___ Right Eye 20/_____
Both Eyes 20/_____ Corrected: Yes/No
Color Vision: Pass / Fail

GENERAL APPEARANCE	NORMAL	ABNORMAL	COMMENTS
Skin			
HEENT			
Neck/Thyroid/Carotid pulses			
Lungs/Chest			
Heart			
Abdomen/Inguinal			
Extremities/Joints			
Spine/Back/ROM			
Neurological/Gait			

IMPRESSION: _____

Tests Ordered:
☐ HBsAB
☐ HBsAG
☐ Rubella, IgG
☐ Rubeola, IgG
☐ Varicella, IgG
☐ Mumps, IgG
☐ Tuberculin Skin Test (TST)
☐ Chest X-ray _____
☐ Other _____

Recommendation:_____
_____
_____

Signature_____License# _____ Date_____

Health Care Provider: ☐ OHS NP ☐ OHS MD ☐ PCP

FOR OHS OFFICE USE ONLY:

TITERS/VACCINE	DATE/STATUS	FOLLOW-UP / DOCUMENTATION
Measles		
Mumps		
Rubella		
Varicella		
PPD 1		
PPD 2		
Chest X-Ray		
Tdap		
Hep B Titer	☐sAB_____ ☐ sAG_____	

Cleared ☐ **Date_____**