



# EMPLOYEE HEALTH HISTORY

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				TODAY'S DATE		
NAME	LAST	FIRST	MIDDLE	DATE OF BIRTH	AGE	SEX
ADDRESS				PHONE NO.		
IN EMERGENCY NOTIFY		RELATIONSHIP		PHONE NO.		
PERSONAL PHYSICIAN & ADDRESS						
DATE LAST SEEN BY THIS PHYSICIAN				REASON & TREATMENT		

## LIST DISEASES, INJURIES OR SURGICAL OPERATIONS LAST TEN YEARS

DATE	DISEASE, INJURY OR SURGERY	SEVERITY & DURATION	OUTCOME

## HEALTH HISTORY QUESTIONNAIRE

Have you ever had or do you currently have any of the following conditions?

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Back Strain/Back Aches | <input type="checkbox"/> Respiratory Allergies/Problems | <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Skin Allergies           |
| <input type="checkbox"/> Back Surgery           | <input type="checkbox"/> Hypertension                   | <input type="checkbox"/> Migraine Headaches      | <input type="checkbox"/> Hernia                   |
| <input type="checkbox"/> Alcoholism/Drug Ad.    | <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Heart Disease or Angina | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> AIDS Virus             | <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Neurological Disorders   |
| <input type="checkbox"/> Epilepsy/Convulsions   | <input type="checkbox"/> Smoker (currently)             | <input type="checkbox"/> Carpel Tunnel           | <input type="checkbox"/> Mental Disorders         |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> PMS/Menstrual Disorders        | <input type="checkbox"/> Shingles                | <input type="checkbox"/> Lupus or Related Disease |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Frequent Colds                 |  |   |

If you checked any conditions, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Give date of following immunizations/test:

Polio	Tine/PPD	Hepatitis B	Tetanus
Rubella/Titer	Rubeola/Titer	Chicken Pox Hx: <input type="checkbox"/> Childhood	<input type="checkbox"/> Unknown <input type="checkbox"/> Titer

Are you able to:

Lift, carry, push, pull, etc light weight equipment or supplies?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	See and hear computer or other types of patient monitors, patient's physical responses or co-worker instructions?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Stand, walk, bend or lift reasonable weight (for your height & size)?	<input type="checkbox"/>	<input type="checkbox"/>	Move quickly in an emergency?	<input type="checkbox"/>	<input type="checkbox"/>
Use hands, arms, back & legs freely & without restrictions?	<input type="checkbox"/>	<input type="checkbox"/>	Tolerate odors related to blood and other body fluids?	<input type="checkbox"/>	<input type="checkbox"/>
Complete an eight hour work shift without excessive rest periods?	<input type="checkbox"/>	<input type="checkbox"/>	Wear personal protective equipment including mask, face protector, gown, & gloves?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered NO to any of these questions, please explain. \_\_\_\_\_

Do you have any physician imposed activity restriction?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you currently under treatment for HIV or HBV exposure? (Medications or follow up blood testing)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have any physical condition which may limit or hinder your performance in an active hospital nursing role?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any open lesions or skin conditions on your face, neck, hands, arms or other exposed parts of your body?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had or are you currently under treatment or are you currently awaiting settlement on a workman's compensation claim?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to Latex?	<input type="checkbox"/>	<input type="checkbox"/>
			Do you need any assistive devices in order to perform your job?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of these questions, please explain. \_\_\_\_\_

LIST CURRENT MEDICATIONS	DRUG ALLERGIES	OTHER ALLERGIES

Current	Height	Weight	B/P	Pulse
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I certify that all the answers and information are correct and complete. I am in good physical and mental health, free of any communicable disease and able to meet the demands of providing patient care,

DATE SIGNATURE

DATE REVIEWER SIGNATURE

The above named individual has been examined by me and found to be in good physical and mental health, free of any communicable disease, and able to meet the demands of his/her profession at full capacity.

Comments or Restrictions \_\_\_\_\_

PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

NAME (PLEASE PRINT) DATE

ADDRESS PHONE