

**Initial Health Assessment**

*Please PRINT all information in black ink (no pencil) clearly and legibly*

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employee  Volunteer Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:  Male  Female

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Int.: \_\_\_\_\_\_\_\_

Home Address/Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notify in case of emergency**

**(1)** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(2)** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Physician**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A. Initial Health Assessment Statement of Purpose**

This Initial Health Assessment is required by the New York State Department of Health, which requires assessment of the health status of all personnel, to assure that personnel are free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of duties. Accordingly this assessment is done for the purpose of determining limitations on your ability to perform your job, whether your job might present a possible risk to you or whether you might present a possible risk to patients or co-workers. IT IS NOT TO BE CONSIDERED AS A SUBSTITUTE FOR YOUR COMPLETE PHYSICAL/ REGULAR MEDICAL CARE BY YOUR PERSONAL PHYSICIAN.

*BY SIGNING BELOW YOU REPRESENT THAT YOU HAVE READ THIS FORM AND BEEN GIVEN THE OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED AND THAT ALL ANSWERS AND STATEMENTS PROVIDED BY YOU ON THIS ASSESSMENT FORM ARE COMPLETE AND TRUE. YOU UNDERSTAND THAT YOUR EMPLOYMENT DEPENDS UPON FULL DISCLOSURE OF ALL NECESSARY JOB RELATED MEDICAL INFORMATION SOUGHT HEREIN AND THAT FALSE OR MISLEADING STATEMENTS COULD LEAD TO DISCIPLINE, UP TO AND INCLUDING YOUR IMMEDIATE DISMISSAL.*

**B. PRIVACY AND ACCESS TO MEDICAL RECORDS:**

The relationship between you and Hospice & Palliative Care (HPCI) is confidential. Medical information will only be released when and if prescribed by law and/or at the written request of the employee. HPCI strictly observes this and all rules of medical ethics. Please note that if necessary, HPCI will communicate to your supervisor about your ability to mentally and physically perform essential job functions with or without restrictions or accommodations and without any threat of harm to yourself or to others. This is done strictly on a need to know basis.

Under the Occupational Safety & Health Act (OSHA Standard 1910.20) employees have the right to see their Employee health medical records and exposure records maintained by their employer, if any, related to potentially toxic substances or potentially harmful biological or physical agents.

**Signature of Employee or Volunteer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee or Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part I. Initial Health Assessment Questionnaire (to be completed by employee)**

1. When did you last receive an influenza vaccination? (Influenza vaccination occurs from October – March each year)

Date: (mm/yyyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Received at:  HPCI  Primary MD/Pharmacy/Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I declined flu vaccine last season.  I decline flu vaccine at present time.

1. Have you been vaccinated for Varicella, Tdap (Tetanus, Diphtheria, Pertussis) And/or MMR (Measles, Mumps, Rubella)  Yes  No
2. Since your last exam, have you had or do you currently have any: *(check all apply)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Unsure** | **New** | **Have now** | **Under Medical Care** |
| **Contagious infectious disease** |  |  |  |  |  |  |
| **Rash** |  |  |  |  |  |  |
| **Diarrhea** |  |  |  |  |  |  |
| **Open sores or dermatitis** |  |  |  |  |  |  |
| **Enlarged lymph nodes** |  |  |  |  |  |  |
| **Fainting spells, dizziness, unexplained loss of consciousness** |  |  |  |  |  |  |

1. Do you have any other health impairment that could impose a potential risk to patients or co-workers or that may interfere with the performance of your job duties?  Yes  No

*If you have answered yes:*

a. Will you need any accommodations to do the essential functions of your new job or volunteer assignment?  Yes  No

b. Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have an addiction or habituation to alcohol, drugs or any other behavior altering substance that may interfere with the performance of your job or volunteer duties or that poses a potential risk to patients or co-workers?  Yes  No

*If you have answered “yes” please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. Do you have any allergies to rubber gloves or latex?  Yes  No
2. Do you have any known allergy to substances used regularly in the performance of your job duties?  Yes  No
3. **Only for employees with direct patient contact responsibilities or at risk for occupational exposure to blood or other potentially infectious materials.** 
   1. Have you had a blood test which shows that you are immune to Hepatitis B?  Yes  No

If you elect not be immunized for Hepatitis B, you must complete a Declination Form which will be kept on file in your medical record. If, at a future date you wish to receive the Hepatitis B Vaccination series, this declination can be withdrawn.

* 1. Have you been immunized for Hepatitis B?

 Previously Vaccinated with Hepatitis B

 Will accept Hepatitis B Vaccination

 Declines Hepatitis B Vaccine

1. Employees Only: Would you like confidential counseling for job related stress?  Yes  No
2. Employees Only: Would you like information to help you stop smoking?  Yes  No

Employee or Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part II. Tuberculosis Screening**

History of positive PPD  Yes  No  Unsure

Completed course of TB Prophylaxis or Treatment  Yes  No  Unsure

Date of last Chest X-Ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Copy of last chest x-ray  Unknown if you tested positive

**TB Symptom Review Questionnaire:**

Please check off any of the following you have experienced in the past twelve months. If there are several choices, check the one(s) which applies to you:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Unsure** | **New** | **Have now** | **Under Medical Care** |
| **Persistent fevers** |  |  |  |  |  |  |
| **Frequent coughing with or w/o phlegm (circle which)** |  |  |  |  |  |  |
| **Coughed up blood** |  |  |  |  |  |  |
| **Night Sweats** |  |  |  |  |  |  |
| **Unplanned weight loss** |  |  |  |  |  |  |
| **Enlarged nodes** |  |  |  |  |  |  |

**Part III. Other**

1. Have you been told by your physician that you have chronic bronchitis, emphysema or any other chest disease?  Yes  No
2. Have you been told by your physician that you have angina or other serious heart disease (NOT including high blood pressure)?

 Yes  No

If yes, have you experienced this in the past six months?  Yes  No

If yes, do you take medication for it?  Yes  No

Have you had chest pains in the past three months?  Yes  No

1. Have you been told by a physician that you have an abnormal heart beat or rhythm?  Yes  No

Reviewed by HPCI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part IV. Medical Exam** *(to be completed, signed and stamped by Medical Practitioner)*

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_ T.P.R \_\_\_\_\_\_\_\_\_

1. **Immunizations and Lab Tests:**

* PPD # 1(Mantoux)  Pos  Neg Date Implanted: \_\_\_\_\_\_\_\_\_\_\_\_ Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PPD # 2: (Mantoux)  Pos  Neg Date Implanted: \_\_\_\_\_\_\_\_\_\_\_\_ Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Chest X-ray: (If PPD is positive)  Pos  Neg Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Attach lab report)
* Rubella  Pos  Neg g Titer: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_
* Rubeola (if born after 12/31/56)  Pos  Neg Titer: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_
* MMR Vaccine (alternate for Rubella & Rubeola) Date: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_
* Varicella Vaccine Date: \_\_\_\_\_\_\_\_\_\_\_\_
* Hepatitis B Vaccine *(optional)* #1 Date: \_\_\_\_\_\_\_ #2 Date: \_\_\_\_\_\_\_ #3 Date: \_\_\_\_\_\_\_\_Titer: \_\_\_\_\_\_\_\_
* **Seasonal Influenza Vaccine *(for applications from Oct. to Mar. only)***  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manufacturer & Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Site of Administration: \_\_\_\_\_\_\_\_\_\_\_\_

Person administering the vaccine:

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reactions (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Review of Systems:**

Cardiovascular \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Muscular \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Digestive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nervous \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Endocrine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reproductive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Excretory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Respiratory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immune \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skeletal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Medication(s):  Yes  No *(If yes, attach list of medications, dosages, and purpose)*

1. **Past Medical History YES NO**

Any serious problems, surgery  

Tuberculosis  

Diabetes  

Mental/Behavioral Disorder  

Cardiovascular Disease  

Hypertension/Hypotension  

Asthma  

Epilepsy/Seizure Disorder  

Cancer  

Kidney Disease  

Drug/Alcohol Abuse  

Allergies  

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  

1. **Tuberculosis (TB) Questionnaire/Screening YES NO**

Exposure to TB at Work/Home  

Positive Chest X-Ray  

Unintended Weight Change (+/- 10 lbs)  

Persistent Cough  

Conversion to Positive PPD  

Low Grade Fever  

Unexplained fatigue  

Blood Streaked Sputum  

Active TB  

Night Sweats  

Loss Appetite  

Clear, Yellow or Dark Sputum  

Notes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have examined the above-named individual and found him/her to be free of any addiction/ habituation to depressants, stimulants, narcotics, illegal drugs, or alcoholic substances.  Yes  No

**Please complete form on next page. ⇒**

I certify that I have examined the above-named individual and found him/her to be:

 Fully Employable – No limitations

 Employable or able to perform Volunteer duties– Suggest Follow Up and/or completion of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Not Currently Employable able to perform Volunteer duties – Recommend Additional Testing /Treatment and/or Follow Up as soon as possible for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Practitioner’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Stamp**:

**Please note:**

* *Physical is not acceptable without Medical Practitioner’s stamp; which includes practitioner’s name, address, phone # and license #. Form must be stamped and signed.*
* *If applicable, a copy of Chest X-Ray Report must be attached*