

Occupational Medicine Forms Checklist

- **Immunization Forms** (2 pages)
- **Health Questionnaire Forms** (4 pages)
The immunization forms and health questionnaire should be completed by your primary care physician. Please bring the completed forms with you to the appointment you schedule with Occupational Medicine.
- **Respirator Medical Evaluation Questionnaire** (3 pages)
Please complete the respirator questionnaire and email to Occupational Medicine before orientation at EHS-Residents@uchc.edu. You cannot get mask-fitted without completing this form and turning it in prior to orientation day.

Pre-Employment Screening and Immunization Documentation

All incoming residents/fellows MUST schedule a medical clearance appointment with Division of Occupational and Environmental Medicine before being cleared to begin.

In order to protect the health of all residents/fellows, employees and patients, all new residents/fellows must undergo immunization/tuberculosis screening performed by Division of Occupational and Environmental Medicine staff before beginning training, payroll, or benefits.

The following are required:

1. Written documentation of vaccination with two doses of live vaccine MMR (measles, mumps, rubella immunization) administered at least 28 days apart, or laboratory documentation of immunity via a positive antibody titer, or laboratory confirmation of disease.
2. Written documentation of vaccination with two doses of varicella vaccine, or laboratory confirmation of disease.
3. Written documentation of a completed series of Hepatitis B vaccination **AND** positive Hepatitis B surface antibody titer. Persons who are determined to have anti-HBs titers less than 10 mIU/ml following the primary series will be offered a second 3-dose series. Non-responders will be tested for HBsAg.
4. Documentation of two PPD skin tests at least 2 weeks apart or Quantiferon TB Gold test within the past 12 months. If there is a history of positive POD or a positive Quantiferon test, a chest x-ray report, if available would be useful.
5. Documentation of adult Tdap
6. Complete of enclosed questionnaires.

In order to facilitate the screening process:

- Please complete the required immunizations/TB skin tests and have your healthcare provider complete and sign the immunization documentation form included in this packet. Do not sign the form yourself. Complete the patient questionnaire/medical history screening form. Bring these documents to your appointment – do not fax or mail them. Please bring your vaccination records and/or immunization titers to your appointment.
- If the immunization/TB test records and antibody titers are not available, we will obtain blood for antibody titers and provide TB skin test/chest x-ray at no charge to you, but this may delay your clearance. If needed, the required vaccinations will also be provided at no charge to you.
- Additionally, you may be required to return to Employee Health Service as scheduled for subsequent PPD skin testing, vaccinations, and/or titers. The Graduate Medical Education (GME) Office will be notified that you are no longer fit for duty should you fail to meet these requirements.
- Complete the respirator questionnaire and email the completed form to EHS-Residents@uchc.edu. This completed form must be returned to Occupational Medicine BEFORE orientation day.

It is prudent to schedule an Occupational Medicine appointment as early as possible, as you cannot begin training without being cleared. When you call (860-679-2893), it is important that you identify yourself as an incoming resident/fellow.

Our contact information:

Employee Health Service/Division of Occupational and Environmental Medicine
263 Farmington Avenue, Outpatient Pavilion, 2nd Floor East
Telephone: 860- 679-2893
Email for residents/fellows only: EHS-Residents@uchc.edu

(Patient Identification)

IMMUNIZATION DOCUMENTATION

First Name _____ Last Name _____ Date of Birth _____

<u>Employee</u>	<u>Resident</u>	<u>Student</u>	<u>Grad Student</u>
Department: _____	Medical Dental	Medical Dental	MPH PhD
Job Title: _____	Start Yr. _____	Start Yr. _____	<u>Post-Doctorate</u>

MMR VACCINATIONS

OR

MMR TITERS

1 st Vaccination	____/____/____	Date of Measles titer	____/____/____	Immune	Not immune
2 nd Vaccination	____/____/____	Date of Mumps titer	____/____/____	Immune	Not immune
		Date of Rubella titer	____/____/____	Immune	Not immune

VARICELLA VACCINATIONS

OR

Varicella Titer

1 st Vaccination	____/____/____	Date of Varicella titer	____/____/____	Immune	Not immune
2 nd Vaccination	____/____/____	Verbal History of illness: (circle) YES	NO		

Tdap (Tetanus diphtheria acellular pertussis) Date of vaccine ____/____/____

TUBERCULOSIS: 2 TUBERCULIN SKIN TESTS OR 1 QUANTIFERON GOLD TEST WITHIN PAST 12 MONTHS REQUIRED

PPD #1	____/____/____	PPD #2	____/____/____
Result (circle)	(mm) Negative Positive	(mm) Negative Positive	
Quantiferon TB Gold -Date	____/____/____ Negative Positive		

If History of positive PPD or Quantiferon, date of most recent chest x-ray ____/____/____ Negative Positive.
BCG History?: (circle) YES NO Please submit copy of report.

HEPATITIS B VACCINATIONS (Vaccination dates AND Titer Required)

1st Dose	____/____/____	4th Dose	____/____/____
2nd Dose	____/____/____	5th Dose	____/____/____
3rd Dose	____/____/____	6th Dose	____/____/____
Titer Date	____/____/____	Titer Date	____/____/____
Titer Result (circle) Positive Negative		Titer Result (circle) Positive Negative	

The documentation above was completed by:

Name of Health Care Provider (print) Telephone Number Address

Signature of Health Care Provider Date/Time

HCH1544

IMMUNIZATION CONSENT / DECLINATION

CONSENT

I have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance to ask questions which were answered to my satisfaction. I understand that due to my occupational exposure, whether by employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated below be given to me or to the person named below for whom I am authorized to make this request.

_____ Relationship _____ Date/Time
Patient or Legal Guardian Signature

Type of Vaccine: MMR (0.5ml subcutaneous)

#1 Date/Time _____ Manufacturer: _____ Lot# _____ Exp _____ Site _____
Diluent Lot # _____ Diluent Exp. Date _____ Provider _____ VIS _____
#2 Date/Time _____ Manufacturer: _____ Lot# _____ Exp _____ Site _____
Diluent Lot # _____ Diluent Exp. Date _____ Provider _____ VIS _____

Type of Vaccine: Tdap / Td (0.5ml intramuscular)

Date/Time _____ Manufacturer: _____ Lot# _____ Exp _____ Site _____
Provider _____ VIS Edition Date _____

Type of Vaccine: Varicella (0.5ml subcutaneous)

#1 Date/Time _____ Manufacturer: _____ Lot# _____ Exp _____ Site _____
Diluent Lot # _____ Diluent Exp. Date _____ Provider _____ VIS _____
#2 Date/Time _____ Manufacturer: _____ Lot# _____ Exp _____ Site _____
Diluent Lot # _____ Diluent Exp. Date _____ Provider _____ VIS _____

DECLINATION

I understand the information provided and explained to me on the vaccine. I understand that due to my employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I have been given the opportunity to be vaccinated with the vaccine. However, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring a serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at that time.

Type of Vaccine: (circle) MMR Varicella Tdap Td

_____ Relationship _____ Date/Time
Patient or Legal Guardian Signature

Reason for Declination: _____

(Patient Identification)

Health Questionnaire

Name _____ Date of Birth _____

Home Address: _____

Home Telephone #: _____ Cell Telephone #: _____

Employer _____ Job Title: _____ Department: _____ Ext: _____

Describe Duties: _____

To your knowledge, which of the categories below best describes the physical demands of your new job?

- Mostly sitting
- Mostly sitting with occasional strenuous physical activity
- Mostly moderately physically active (at least 2 hours per day)
- Mostly strenuous activity, ie., lifting and carrying more than 10 pounds frequently during the work day.

Do you have any personal health problems that might be affected by work or workplace exposures? No Yes

If yes, please explain _____

WORK AND EXPOSURE HISTORY: Briefly describe previous jobs, titles, duties and dates:

Start Date	End Date	Employer	Job Title/Duties	Exposure

Have you ever lost more than one week of work-time or changed your job because of an illness or injury (either work or non-work related)? No Yes

If yes, please describe: _____

Have you worked in an environment that was sufficiently noisy that hearing testing or hearing protection was recommended?

No Yes Please describe _____

Have you spent time in an environment where you needed to receive treatment for exposure to chemicals or other environmental agents (e.g. mold, pepper spray, lead, isocyanates, tuberculosis,)? No Yes If yes, please describe:

Are you are exposed to any other hazards at home or doing hobbies or current part-time jobs? No Yes

Please List: _____

Have you ever changed your residence or home because of health problems? No Yes If yes, please describe:

(Patient Identification)

Health Questionnaire

Do you live near an industrial plant or hazardous waste site? No Yes If yes, please describe:

MEDICAL HISTORY – Check if you have or have had any of the following and give the year.

Illness	Yes	Illness	Yes	Illness	Yes
Dizziness, loss of consciousness, or fainting		Sinus problems, nasal congestion, persistent or recurrent cough		Ear infection, ruptured ear drum, hearing loss, or hearing deficit	
Heart problems, irregular heartbeats, skipped beats, palpitations		Throat or voice problems, difficulties swallowing, thyroid disease		Epilepsy or seizures	
Angina, heart attack, congestive heart failure, enlarged heart, or heart murmur		Varicose veins, leg swelling, or leg sores		Neurological disorder, difficulties with balance, coordination, speech, memory, or use of limbs	
High blood pressure or elevated cholesterol levels		Hernia		Head injuries, migraines, frequent headaches	
Chest tightness, chest pain, shortness of breath		Weight change (increase or loss without trying)		Elbow, wrist, or hand problems	
Diabetes, high blood sugar, or low blood sugar		Anemia, blood clots, or other blood disorder		Carpal tunnel syndrome, tingling or numbness in hands	
Cancer or immunodeficiency		Pinched nerve or disc problem		Bursitis/ tendonitis	
Recurrent bronchitis, emphysema, pneumonia, or other lung disease		Sleep apnea, difficulties sleeping, or other sleep disorder		Recurrent neck problems – strain, sprain, whiplash, stiffness	
Asthma, breathing problems, or wheezing		Vision problems		Shoulder problems/injury such as rotator cuff injury	
Tuberculosis		Absent spleen		Tendonitis/repetitive strain Injury	
Skin rashes; psoriasis, eczema, other skin sensitivity		Urinary or kidney problems		Hip, knee, ankle or foot problems	
Anxiety, depression that interferes with function, overwhelming stress, mood disorder, phobias or fears		Mental health condition that may interfere with concentration or interpersonal relationships		Recurrent back problems – sprain, strain, injury, stiffness	
Liver problems, hepatitis, cirrhosis, or pancreas problems		Gastrointestinal Disease – GERD, ulcers, bowel disease, irritable bowel syndrome, blood in stools		Arthritis, Lyme Disease, or other joint problems	
Weakness or chronic fatigue		Multiple chemical sensitivities, or sensitivities to odors or fragrances		Chronic pain, fibromyalgia, myofascial pain disorder, or muscle problems	
Connective tissue disorder such as Lupus, Sarcoidosis, Sjogren's Syndrome		Alcoholism or drug addiction		Difficulties standing, walking, climbing, using stairs	

Please comment on the above conditions:

(Patient Identification)

Health Questionnaire

Have you ever had back pain or injury which disrupted your usual activities No Yes If yes, please describe all episodes which resulted in absence from work or school (include dates):

Do you have any other medical condition not identified above? Please describe and give dates:

Please list current medications:

Do you have a current medical condition that may require workplace accommodations? No Yes If yes, please describe.

Have you ever received disability benefits? No Yes

If yes, explain

Have you ever received an impairment rating and/or disability rating? No Yes

If yes, explain

Do you have any work limitations? No Yes If yes, explain

Have you ever been hospitalized? Yes No

Please list any hospitalizations and/or surgeries for major medical illnesses, injury, or procedures:

ALLERGY HISTORY

Please list any medication allergies

Please list any allergies to animals

Please list any allergies or sensitivities to chemicals, odors, fragrances, or environmental and/or indoor air allergens

Are you allergic to protective gloves or Latex (glove dermatitis) No Yes

(Patient Identification)

Health Questionnaire

TOBACCO/ALCOHOL

Do you use tobacco? No, never No, but I did in the past Yes, currently

If you ever used tobacco, what did you use? Cigarettes Pipe or Cigars Chewing

How old were you when you started to use tobacco? _____

How old were you when you stopped? _____

How much, on average, did you smoke when you were smoking?

_____ packs cigarettes/day or _____ cigars/pipes per week

Do you drink alcohol? No Yes If yes, how many drinks do you average per day? _____

HEALTH MAINTENANCE

Do you currently have a primary care physician? No Yes

If yes, name _____

Do you exercise regularly? No Yes If yes please describe _____

Do you have routine medical exams? Yes No

Have you completed a Hepatitis B vaccine series? Yes No

Do you receive the influenza vaccine annually? Yes No

Do you wear a seatbelt in a car? Yes No

SCREENING EXAMS

What year was your last complete physical exam? _____

What year was your last vision (eye) exam? _____

What year was your last dental cleaning? _____

For women only, what year was your last cervical cancer screening (Pap smear)? _____

For women only, what year, if any, was your last mammogram? _____

What year was your last cholesterol screening test? _____

What year, if any, was your last colon cancer screening? _____

I understand that the purpose of this exam is to screen for medical and physical conditions, assess whether substantial risks to me and/or to others may exist as these relate to the performance of essential job functions and, if so, recommend reasonable workplace accommodations.

I understand that the details of the exam remain confidential within the medical record, but the employer may be advised regarding the need for accommodation and specific accommodations may be recommended.

I understand that the ability to accommodate medical conditions and final employment decisions are determined by the employer.

I certify to the best of my knowledge that the above information is complete and true.

I understand that this evaluation (history review and physical exam) is related to my job and does not replace routine health care and physical examinations by my own doctor.

Patient Signature: _____ Date _____ Time _____

Reviewed By: _____ Date _____ Time _____