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 mlU/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
# IMMUNIZATION DOCUMENTATION

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employee</th>
<th>Resident</th>
<th>Student</th>
<th>Grad Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>Medical</td>
<td>Medical</td>
<td>MPH</td>
</tr>
<tr>
<td>Job Title:</td>
<td>Dental</td>
<td>Dental</td>
<td>PhD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MMR VACCINATIONS</th>
<th>MMR TITERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Vaccination</td>
<td>Date of Measles titer</td>
</tr>
<tr>
<td>2nd Vaccination</td>
<td>Date of Mumps titer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Varicella Vaccinations</th>
<th>Varicella Titer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Vaccination</td>
<td>Date of Varicella titer</td>
</tr>
<tr>
<td>2nd Vaccination</td>
<td>Verbal History of illness: (circle)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TdAp (Tetanus diphtheria acellular pertussis)</th>
<th>Date of vaccine</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tuberculosis: 2 Tuberculin skin tests or 1 Quantiferon Gold Test within past 12 months required</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD #1</td>
<td>PPD #2</td>
</tr>
<tr>
<td>Result (circle) (mm)</td>
<td>Positive</td>
</tr>
<tr>
<td>Quantiferon TB Gold - Date</td>
<td>Negative</td>
</tr>
</tbody>
</table>

If History of positive PPD or Quantiferon, date of most recent chest X-ray | Negative | Positive. |

<table>
<thead>
<tr>
<th>Hepatitis B Vaccinations (Vaccination dates AND Titer Required)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Dose</td>
<td>4th Dose</td>
</tr>
<tr>
<td>2nd Dose</td>
<td>5th Dose</td>
</tr>
<tr>
<td>3rd Dose</td>
<td>6th Dose</td>
</tr>
<tr>
<td>Titer Date</td>
<td>Titer Date</td>
</tr>
<tr>
<td>Titer Result (circle)</td>
<td>Positive</td>
</tr>
</tbody>
</table>

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.

Patient or Legal Guardian Signature __________________________ Relationship __________ Date/Time __________

Type of Vaccine: **MMR** (0.5ml subcutaneous)

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Manufacturer</th>
<th>Lot#</th>
<th>Exp</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diluent Lot</td>
<td>Diluent Exp. Date</td>
<td>Provider</td>
<td>VIS</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Manufacturer</th>
<th>Lot#</th>
<th>Exp</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>VIS Edition Date</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type of Vaccine: **Varicella** (0.5ml subcutaneous)

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Manufacturer</th>
<th>Lot#</th>
<th>Exp</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diluent Lot</td>
<td>Diluent Exp. Date</td>
<td>Provider</td>
<td>VIS</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diluent Lot</td>
<td>Diluent Exp. Date</td>
<td>Provider</td>
<td>VIS</td>
<td></td>
</tr>
</tbody>
</table>

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 |

Patient or Legal Guardian Signature __________________________ Relationship __________ Date/Time __________

Reason for Declination: __________________________
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, i.e., 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:

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Employer</th>
<th>Job Title/Duties</th>
<th>Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>________</td>
<td>________</td>
<td>________________</td>
<td>________</td>
</tr>
<tr>
<td>__________</td>
<td>________</td>
<td>________</td>
<td>________________</td>
<td>________</td>
</tr>
</tbody>
</table>

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:
_____________________________________________________________________________________

_____________________________________________________________________________________

*HCH1553*
**Health Questionnaire**

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

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

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

Please comment on the above conditions:

__________________________________________________________________________________________
__________________________________________________________________________________________
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
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__________