NAME: ______________________________
DATE OF BIRTH: ______________________________
ADDRESS: ______________________________
PHONE: (H) ______________(W) ______________
DEPARTMENT: Volunteer Services
SOCIAL SECURITY NUMBER: ______________________
SEX: Male_______ Female_______

CAMC
Charleston Area Medical Center

EMPLOYEE HEALTH SCREEN

MEDICAL HISTORY (Please check and if answer is "yes", describe under remarks. Give item number.)

HAVE YOU EVER HAD?	No	Yes	Year (if yes)	HAVE YOU EVER HAD?	No	Yes	Year (if yes)	HAVE YOU EVER HAD?	No	Yes	Year (if yes)
1. Head Injury Loss consciousness				22. Thinking or sleeping trouble				43. Are you allergic to chicken eggs or neomycin?			
2. Frequent headaches/migraines				23. Gall bladder or liver disease				44. Are you presently under treatment for an illness or injury?			
3. Dizzy or fainting spells				24. Yellow jaundice or hepatitis				45. Eye trouble, vision problem(s)			
4. Mental, anxiety, depression, panic attacks				25. Blood in stools or urine				46. Are you taking any medications?			
5. Seizures, epilepsy, convulsions				26. Change in bowel habits				47. Unusual weight gain or loss			
6. Lung disease or emphysema				27. Skin disease or rash				48. Eyes examined for glasses			
7. Asthma, hay fever, sinus				28. Kidney trouble – stones				49. Are glasses adequate?			
8. Allergy				29. Rupture or hernia				50. Have you ever been x-rayed? Last chest x-ray (date __________)			
9. Blindness, color blindness				30. Varicose veins, leg ulcers				51. Have you ever been rejected for employment for medical reasons?			
10. Ear trouble, decreased hearing				31. Rheumatism, arthritis, gout				52. Have you ever been rejected for life insurance?			
11. Ringing in the ears				32. Deformity, amputations				53. Last menstrual period (date/as applicable)	Mo	Dy	Year
12. Diabetes				33. Stiff joints, trick shoulders or knees				54. Severe cramps			
13. Tuberculosis, coughing up blood				34. Back trouble, ruptured disc, pinched nerve				55. Serious infection			
14. Shortness of breath				35. Fractures (a bone or bones broken)				56. Urine problem			
15. Swelling of legs or ankles				36. Operations or injuries				57. Thyroid gland disease			
16. Chest pain or discomfort				37. Hospitalized for illness or injuries				58. Have your relatives had Tuberculosis?			
17. Coughing or wheezing				38. Scars, identifying marks				59. Have your relatives had Diabetes?			
18. Heart trouble heart attack				39. Cancer or tumor				60. Seen a doctor in 2 years			
19. High blood pressure				40. Blood disease or anemia				61. Ever seen a counselor or psychiatrist			
20. Stroke, paralysis or numbness				41. Military service				62. Fear of heights			
21. Stomach trouble, ulcers, acid reflux				42. Rejected for military service				63. Latex allergy			

Please list all medications you are currently taking: ______________________________
Medication Allergies: ______________________________
Have you ever had a Tuberculin Skin Test: ☐Yes ☐No Have you ever had a tetanus shot? ☐Yes ☐No Date ______________
Have you ever had Hepatitis B Vaccine? ☐Yes ☐No Date completed: ______________
Current or anticipated job: ______________________ Previous Jobs: ______________________
Ever drink alcoholic beverages? ☐Yes ☐No Do you smoke? ☐Yes ☐No ________ Treated for substance abuse? ☐Yes ☐No
Are you unable to perform certain motions, assume certain positions, or lift heavy objects? ☐Yes ☐No
Explain: ______________________________

REMARKS (indicate item number from above):

____

____

____

I hereby certify that the above answers are true and correct.

______________________ ______________________________
DATE SIGNATURE

***STOP!* Reverse side to be filled out by Employee Health.**

*FOR EMPLOYEE HEALTH USE ONLY

GENERAL APPEARANCE: HEIGHT __________ WEIGHT __________ **BUILD:** ☐*OBESE* ☐*AVERAGE* ☐*THIN* **AGE:** ____

VISION:
Wear glasses or contacts? ☐ No ☐ Yes
Color vision: ☐ Normal ☐ Color Blind

HEARING:
(Spoken voice) Right ______________ Left ____________
☐ Audiogram

OTHER TESTS AND SPECIAL PROCEDURES:
☐ PFT: ________________________
☐ Chest x-ray: ________________________
☐ Drug Screen ________________________
☐ Tdap ________________________
☐ Flu Vax ________________________
☐ HBV ________________________

BLOOD PRESSURE:
Right arm ______________ Left arm ______________

Repeat blood pressure:
Date ______________
Systolic ______________ Diastolic ______________

Date ______________
Systolic ______________ Diastolic ______________

OTHER LABORATORY:
____

☐Measles ☐Varicella ☐TB-Quant
☐Mumps ☐HbsAg ☐Hep C
☐Rubella ☐HBsAb ☐

EXAMINE AND RECORD UNDER "COMMENTS" DEFECTS OF:		
	✓ Normal	× See Comments
1. Deformity		
2. Squats		
3. Bends to touch floor		
4. Heel/toe		
5. Straight leg raises		

COMMENTS:

____
____
____
____

RESULTS OF EXAMINATION:
- ☐ Examination normal ☐Special placement required: ______________
- ☐ Delay placement pending further testing/medical information: ______________
- ☐ Examination revealed non job-related health conditions. These were discussed with patient.
- ☐ Follow-up recommendations: ________________________

______________________ DATE

______________________ SIGNATURE

Revised 6/1/16