

Northern New England Emergency Medical Response Team
CONFIDENTIAL
Pre-Placement Health Questionnaire

Cover Sheet

Name: _____

Date of Birth: / / _____
(MM/DD/YYYY)

Sex: **Male** **Female**
(Circle One)

Mailing Address: _____
(This address will be used
if Occupational Medicine
needs to send you written
communication.) _____

Telephone: () _____
(This number will be used
if Occupational Medicine
needs to contact you via
telephone.)

Northern New England Emergency Medical Response Team
CONFIDENTIAL
Pre-Placement Health Questionnaire

PURPOSE:

- ❖ To identify any illness or disability that may affect a Strike Team member's ability to perform the essential functions of their position with or without accommodation.
- ❖ To ensure that Strike Team members meet all State Public Health and Infection Control requirements.
- ❖ To establish baseline data for medical surveillance for specific occupational exposures (examples: tuberculosis, respirator use, Hepatitis B).
- ❖ To ensure compliance with OSHA standards.

This information is maintained by the Section of Occupational and Environmental Medicine at DHMC and is protected by Federal and State Law.

Please complete this questionnaire in your own writing. All yes answers should be fully explained in the comments section of each section. Please note: This is not a diagnostic examination. The purpose of this questionnaire is to evaluate your fitness to perform specific job tasks and to ensure the safety of yourself and others. After review of your responses, a health care provider will advise you of any concerns that should be investigated further.

~~~~~

**Work History:**

**Strike Team Position:** \_\_\_\_\_

**Describe job duties of this position:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Regular Work Position(s):** \_\_\_\_\_

**Describe job duties of this position:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Some assignments may involve exposure to noise, chemicals, bio-hazards, and various forms of radiation. An individual's history of exposure and tolerance to these agents must be considered. Considering this, carefully answer the following questions:**

Have you ever:

Yes  No Worked with ionizing radiation or radioactive substances?

Yes  No Worked with microwaves, lasers, or masers?

Yes  No Worked with toxic or hazardous substances such as (circle all applicable responses)

Acrylics                      Advanced composites      Anti-neo-plastics

Anesthetic agents      Arsenic                      Asbestos

Benzene                      Beryllium                      Blood/body fluids

Cadmium                      Coal tar derivatives      Ethylene Oxide

Formaldehyde              Glycol Ethers              Lead

Pesticides                      Mercury                      Silicates

Solvents                      Other: Please list: \_\_\_\_\_

Yes  No Incurred an exposure to blood or body fluids?

Yes  No Been poisoned by chemicals, gasses, fumes, metals, etc?

Yes  No Become allergic to any chemicals with which you have worked?

Yes  No Had periodic physical examinations because of exposure to hazardous materials?

Yes  No Left a job or changed your occupation because of health problems related to exposure to noise, chemicals, or radiation?

Yes  No Worked in a job that was noisy, made your ears ring, or made it hard for you to hear?

Yes  No Had a hearing test or worn ear protectors?

Yes  No Been told by a doctor to limit or restrict your work activities because of exposure to noise, chemicals, or radiation?

**“Second injury” funds have been established under various State Workers’ Compensation programs to encourage employers to hire individuals with a history of prior industrial injuries. Inappropriate work assignments can aggravate previous job related injuries. Considering this, carefully answer the following questions:**

Have you ever:

Yes  No      Lost time from work because of a job related accident or illness?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No      Filed a workers’ compensation claim because of a job related injury?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No      Filed a workers’ compensation claim that is still open or pending?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No      Received a disability award or pension for a job related accident or illness?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have any current work restrictions?**  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**All Team members who provide direct patient care and/or work in patient care areas, must be immune to measles (rubeola), rubella and varicella (chickenpox).**

**PLEASE ATTACH COPIES OF VACCINATION HISTORY, AND/OR SEROLOGICAL TESTING and COMPLETE THE FOLLOWING:**

***Have you ever had any of the following childhood diseases AND/OR immunizations?***

|     |     | <u>DISEASE</u>           | <u>IMMUNIZATION</u> |
|-----|-----|--------------------------|---------------------|
| ___ | Yes |                          |                     |
| ___ | No  | Measles (Rubeola)        | DATES*: _____       |
| ___ | Yes |                          |                     |
| ___ | No  | German Measles (Rubella) | DATES*: _____       |
| ___ | Yes |                          |                     |
| ___ | No  | Chickenpox (Varicella)   | DATES*: _____       |
| ___ | Yes |                          |                     |
| ___ | No  | Mumps                    | DATES: _____        |
| ___ | Yes |                          |                     |
| ___ | No  | dT (Diphtheria/Tetanus)  | DATES: _____        |
| ___ | Yes |                          |                     |
| ___ | No  | Poliomyelitis            | DATES: _____        |

\*If documentation of disease, serology or immunization records are not provided, serological testing will be needed to establish immunity. By providing documentation of these immunizations and/or previous serological testing of immunity, you help conserve resources and avoid repeating these tests.

**All Strike Team members are required to participate in a Tuberculosis Surveillance Program which includes annual PPD skin testing or, for those individuals with previous documented latent tuberculosis infection (a positive PPD), completion of a symptom questionnaire, a report of a recent chest Radiograph, and medical evaluation with an Occupational Medicine clinician. Please provide documentation of your most recent PPD or if you have had a prior positive PPD, please provide your most recent symptom questionnaire, chest x-ray, and records of a medical evaluation.**

PPD SKIN TEST:

Result of most recent PPD skin test: \_\_\_\_\_ DATE: \_\_\_\_\_

Have you previously had a **positive** TB skin test? \_\_\_ Yes \_\_\_ No

If YES, please give date, and describe management and current status, including date of most recent chest Radiograph (if applicable): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HEPATITIS B:

Have you received the Hepatitis B Vaccination series: \_\_\_ Yes \_\_\_ No

If yes, dates: \_\_\_\_\_

If no, and you choose not to get the series, you must provide a copy of a declination form

Did you have a Hepatitis B Antibody titer drawn post-vaccination?

\_\_\_ Yes \_\_\_ No \_\_\_ Unsure

If YES, please give date and result: \_\_\_\_\_

If you have not had the Hepatitis B series, it will be offered to you at no charge. A written declination will be required if you elect not to receive the vaccine as per the OSHA Blood Borne Pathogen Standard.

*PLEASE PROVIDE COPIES OF ALL VACCINATION RECORDS AND/OR SEROLOGICAL EVIDENCE OF IMMUNITY AND SEND IN WITH THIS QUESTIONNAIRE.*

**Other Immunizations**

*Have you ever had any of the following immunizations?*

|                | <u>DISEASE</u>          | <u>IMMUNIZATION</u> |
|----------------|-------------------------|---------------------|
| ___ Yes ___ No | Cholera                 | DATES: _____        |
| ___ Yes ___ No | Hepatitis A             | DATES: _____        |
| ___ Yes ___ No | Influenza               | DATES: _____        |
| ___ Yes ___ No | Japanese B Encephalitis | DATES: _____        |
| ___ Yes ___ No | Meningococcal Disease   | DATES: _____        |
| ___ Yes ___ No | Rabies                  | DATES: _____        |
| ___ Yes ___ No | Tick-borne Encephalitis | DATES: _____        |
| ___ Yes ___ No | Typhoid                 | DATES: _____        |
| ___ Yes ___ No | Yellow Fever            | DATES: _____        |
| ___ Yes ___ No | Smallpox                | DATES: _____        |

*PLEASE PROVIDE COPIES OF ALL VACCINATION RECORDS AND/OR SEROLOGICAL EVIDENCE OF IMMUNITY AND SEND IN WITH THIS QUESTIONNAIRE.*

**RESPIRATOR MEDICAL CLEARANCE: The following questions are required per the OSHA Respirator Standard in order to determine medical eligibility to wear a respirator.**

**If medically eligible to wear a respirator, you will be fitted.**

Respirators that may be used by Strike Team Staff include: the Triosyn T-3000, P95 respirators, and Powered Air Purifying Respirators (PAPR).

Approximate Height: \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

Every employee who has been selected to use any type of respirator must provide the following information (please print).

1. Today's date: \_\_\_\_\_
2. Your Name: \_\_\_\_\_
3. Your age (to nearest year): \_\_\_\_\_
4. Sex (circle one): Male / Female
5. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
6. Your weight: \_\_\_\_\_ lbs.
7. Your job title: \_\_\_\_\_
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code): \_\_\_\_\_
9. The best time to phone you at this number: \_\_\_\_\_
10. Has your employer told you how to contact the health care provider who will review this questionnaire (circle one): Yes / No
11. Check the type of respirator you will use (you can check more than one category):

|                                                                                  |                                                                                                                                           |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only) | b. _____ Other type (for example, half-or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus). |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|

12. Have you worn a respirator (circle one): Yes / No

If "yes" what types(s): \_\_\_\_\_

Any difficulty with respirator use? Please describe: \_\_\_\_\_

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

**Every employee who has been selected to use any type of respirator must answer questions 1 through 9 below (please circle "yes" or "no").**

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes / No  
Amount: \_\_\_\_\_

2. Have you ever had any of the following conditions?

|                                                          |          |                   |          |
|----------------------------------------------------------|----------|-------------------|----------|
| a. Seizures                                              | Yes / No | b. Diabetes       | Yes / No |
| c. Allergic reactions that interfere with your breathing | Yes / No | d. Claustrophobia | Yes / No |
| e. Trouble smelling odors                                | Yes / No |                   |          |

3. Have you ever had any of the following pulmonary or lung problems?

|                |          |                                    |          |                                                    |          |
|----------------|----------|------------------------------------|----------|----------------------------------------------------|----------|
| a. Asbestosis  | Yes / No | b. Asthma                          | Yes / No | c. Chronic bronchitis                              | Yes / No |
| d. Emphysema   | Yes / No | e. Pneumonia                       | Yes / No | f. Tuberculosis                                    | Yes / No |
| g. Silicosis   | Yes / No | h. Pneumothorax (collapsed lung)   | Yes / No | i. Lung cancer                                     | Yes / No |
| j. Broken ribs | Yes / No | k. Any chest injuries or surgeries | Yes / No | l. Any other lung problems you've been told about? | Yes / No |

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

|                                                                                           |          |
|-------------------------------------------------------------------------------------------|----------|
| a. Shortness of breath                                                                    | Yes / No |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill      | Yes / No |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground | Yes / No |
| d. Have to stop for breath when walking at your own pace on level ground                  | Yes / No |
| e. Shortness of breath when washing or dressing yourself                                  | Yes / No |
| f. Shortness of breath that interferes with your job                                      | Yes / No |
| g. Coughing that produces phlegm (thick sputum)                                           | Yes / No |
| h. Coughing that wakes you early in the morning                                           | Yes / No |
| i. Coughing that occurs mostly when you are lying down                                    | Yes / No |
| j. Coughing up blood in the last month                                                    | Yes / No |
| k. Wheezing                                                                               | Yes / No |
| l. Wheezing that interferes with your job                                                 | Yes / No |
| m. Chest pain when you breathe deeply                                                     | Yes / No |
| n. Any other symptoms that you think may be related to lung problems:<br>_____            | Yes / No |

5. Have you ever had any of the following cardiovascular or heart problems?

|                 |          |                                              |          |
|-----------------|----------|----------------------------------------------|----------|
| a. Heart Attack | Yes / No | e. Swelling in your legs or feet             | Yes / No |
| b. Stroke       | Yes / No | f. Heart arrhythmia (heart beat irregularly) | Yes / No |

|                  |          |                                                                      |          |
|------------------|----------|----------------------------------------------------------------------|----------|
| c. Angina        | Yes / No | g. High blood pressure                                               | Yes / No |
| d. Heart failure | Yes / No | h. Any other heart problem you've been told you have: _____<br>_____ | Yes / No |

6 Have you ever had any of the following cardiovascular or heart symptoms?

|                                                                                             |          |
|---------------------------------------------------------------------------------------------|----------|
| a. Frequent pain or tightness in your chest                                                 | Yes / No |
| b. Pain or tightness in your chest during physical activity                                 | Yes / No |
| c. Pain or tightness in your chest that interferes with your job                            | Yes / No |
| d. In the past two years, have you noticed your heart skipping or missing a beat            | Yes / No |
| e. Heartburn or indigestion that is not related to eating                                   | Yes / No |
| f. Any other symptoms that you think may be related to heart or circulation problems: _____ | Yes / No |

7. Do you currently take medication for any of the following problems?

|                               |          |                    |          |
|-------------------------------|----------|--------------------|----------|
| a. Breathing or lung problems | Yes / No | b. Heart trouble   | Yes / No |
| c. Blood pressure             | Yes / No | d. Seizures (fits) | Yes / No |

If yes to any questions above, please fully describe here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9): \_\_\_\_\_

|                                                                    |          |                                |          |
|--------------------------------------------------------------------|----------|--------------------------------|----------|
| a. Eye irritation                                                  | Yes / No | b. Skin allergies or rashes    | Yes / No |
| c. Anxiety                                                         | Yes / No | d. General weakness or fatigue | Yes / No |
| e. Any other problem that interferes with your use of a respirator |          |                                | Yes / No |

9. Would you like to talk to the health professional who will review this questionnaire about your answers to this questionnaire? Yes / No

**WORK FITNESS: While specific professional duties will vary by team member position, there are general physical and cognitive requirements that are applicable across the spectrum of Strike Team Duties. The following list is not meant to be all inclusive.**

**A basic list for Strike Team Members includes the ability, without the use of an intermediary, to:**

- \* **Take a history and perform a physical examination.**
- \* **Perform cardiopulmonary resuscitation.**
- \* **Communicate with patients and staff, verbally and otherwise in a manner that exhibits good professional judgment and is appropriate for the professional setting.**
- \* **Read charts and monitors.**

- \* **Perform documentation procedures, such as chart dictation and other paperwork, in a timely fashion.**
- \* **Easily move throughout the Strike Team austere work environment to address routine and emergent patient care issues.**
- \* **Take call for the service, which may require work intervals of up to 30 hours.**
- \* **Perform professional duties in a reliable fashion for up to 80 hours/week.**
- \* **Input and retrieve computer data through a keyboard and read a computer screen.**
- \* **Make judgments and decisions regarding complicated, undifferentiated disease presentations in a timely fashion in emergency, ambulatory, and hospital settings with appropriate supervision.**

Based upon the above and your understanding of your job description, do you believe you can meet all the duties and responsibilities of the job? Yes / No

If NO, please explain: \_\_\_\_\_

How would you rate your level of physical activity? (Physical activity includes work and leisure activities which require sustained exertion such as walking briskly, running, lifting and carrying moderately heavy items for 20 minutes.)

- Level 1: little or no physical activity \_\_\_\_\_
- Level 2: occasional physical activity \_\_\_\_\_
- Level 3: regular physical activity at least 3 times per week \_\_\_\_\_

Do you have any unexplained fever, chills, night sweats, weight loss, loss of energy, fatigue, diarrhea, or urinary symptoms? Yes / No

If YES, please explain: \_\_\_\_\_

Are you suffering from any contagious diseases at this time? Yes / No

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have any other medical or mental health conditions, which you feel would interfere with your job performance? Yes / No

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

How long has it been since your last physical examination?

- less than 1 year \_\_\_\_\_
- 1-3 years \_\_\_\_\_
- more than 3 years \_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Are you currently, or have you ever, been treated for substance abuse?

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Have you ever tried to cut down on your alcohol or drug use?

\_\_\_\_ Yes \_\_\_\_ No Do you get annoyed when people comment about your drinking or drug use?

|                          |     |                          |    |                                                                                                                                                                                     |
|--------------------------|-----|--------------------------|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you feel guilty about things you have done while drinking or using drugs?                                                                                                        |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you need an eye-opener to get started in the morning?                                                                                                                            |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you have a current or past history of mental illness, e.g.: depression, bi-polar disorder, panic disorder, anxiety disorder, schizophrenia, PTSD, Obsessive compulsive disorder? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Are you currently receiving treatment for any of the above?                                                                                                                         |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you experienced difficulty working or attending school due to stress, anxiety, depression, panic disorder, etc?                                                                |
|                          |     |                          |    | If yes, please explain: _____<br>_____                                                                                                                                              |

Have you ever had any form of allergy (e.g., hay fever)? Yes / No

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

Are you allergic to or have you had a “reaction” to any medicines, foods, latex (rubber) products?  
Yes / No

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Some job assignments could be dangerous in the event of dizziness, loss of consciousness, or loss of equilibrium or these conditions may interfere with your ability to provide care. Do you have any condition which may:**

|                          |     |                          |    |                                                                                              |
|--------------------------|-----|--------------------------|----|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Affect your equilibrium or ability to maintain your balance?                                 |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Alter your normal state of consciousness or cause you to become unconscious?                 |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Make it dangerous for you to work at unguarded hazardous heights or around moving machinery? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Prohibit you from driving vehicles on public highways?                                       |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Prohibit you from working alone in remote, isolated, or confined spaces?                     |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Limit your ability to perform very strenuous physical activity?                              |

Do you have any pain, numbness, or loss of feeling:

- a.) In either hand? Yes / No
- b.) Has it limited the use of your hand or your ability to maintain a strong grip or hold objects firmly or handle objects with your fingers? Yes / No
- a.) In either arm or shoulder? Yes / No
- b.) Has it reduced your strength or limits normal range of motion? Yes / No
- a.) In either foot or leg? Yes / No

- b.) Has it caused weakness or limits to range of motion or your ability to stand, walk, squat, kneel or climb stairs? Yes / No
- a.) In your neck? Yes / No
- b.) Has it interfered with bending or turning your neck and holding it in any one position for any length of time? Yes / No
- a.) In your back? Yes / No
- b.) Has it caused or reduced strength or interfered with your ability to bend your back often; to lift, carry, push or pull heavy objects; or to work in a stooped or squatting position? Yes / No

If you have responded yes to any of the above, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you regularly taking any medication which you feel might affect your work performance at the present time? Yes / No

If you answered YES, please list **all** the medications you are taking:

| <b>List Current Medications</b> | <b>Dosage</b> | <b>Reason</b> |
|---------------------------------|---------------|---------------|
| _____                           | _____         | _____         |
| _____                           | _____         | _____         |
| _____                           | _____         | _____         |
| _____                           | _____         | _____         |
| _____                           | _____         | _____         |
| _____                           | _____         | _____         |

**Please list all surgeries and hospitalizations, including dates:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For Females Only**

Are you currently pregnant: Yes / No

If yes, what is your EDC (expected date of confinement or due date): \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Date of last mammogram (if appropriate): \_\_\_\_\_

**Social History**

***Hobbies***

List concurrent jobs/hobbies, sports, and home activities: \_\_\_\_\_

\_\_\_\_\_

Do you regularly exercise? (*running, jogging, swimming, walking, aerobics, etc*)    Yes / No

**Smoking History**

***(Nicotine or Tobacco)***

Number of packs/pouches/tins per day: \_\_\_\_\_      Number of years: \_\_\_\_\_

Personal Health Care Provider: \_\_\_\_\_

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

\_\_\_\_\_

Phone: \_\_\_\_\_

Applicant Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Examiners Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***I have answered the questions to the best of my knowledge. I understand that this questionnaire is to assist Occupational Medicine staff in determining my medical suitability to safely perform the functions of a STRIKE TEAM MEMBER.***

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

PLEASE ATTACH ALL VACCINATION RECORDS, PPD TESTS, AND LAB TESTS TO THIS QUESTIONNAIRE. IT SHOULD BE MAILED TO:

OCCUPATIONAL MEDICINE  
DHMC  
1 MEDICAL CENTER DRIVE  
LEBANON, NH 03756

A PRE-ADDRESSED POSTAGE-PAID ENVELOPE IS INCLUDED IN YOUR STIKE TEAM MEDICAL PACKET FOR YOUR CONVENIENCE.

THANK YOU FOR COMPLETING THE STRIKE TEAM PRE-PLACEMENT HEALTH QUESTIONNAIRE. PLEASE LEAVE THE FOLLOWING THREE PAGES BLANK FOR AN OCCUPATIONAL MEDICINE CLINICIAN TO FILL OUT. IT WILL BE UTILIZED IN SITUATIONS WHERE A PHYSICAL EXAM IS INDICATED.

**OCCUPATIONAL MEDICINE CLINICIAN COMPONENT  
PHYSICAL ASSESSMENT**

|                         |         |                    |                                             |                   |       |                 |  |
|-------------------------|---------|--------------------|---------------------------------------------|-------------------|-------|-----------------|--|
| Height:                 | Weight: | Temp:              | Hearing: (if audiometry not included) R: L: |                   |       |                 |  |
| Blood Pressure: R L     |         | Color Vision:      |                                             | Depth Perception: |       |                 |  |
| Pulse:                  | Rhythm: | Visual Perception: |                                             | With glasses      |       | Without Glasses |  |
|                         |         |                    | Right                                       | Left              | Right | Left            |  |
| Spirometry: FVC: FEV-1: |         | Far Vision         | 20/                                         | 20/               | 20/   | 20/             |  |
| Dominant Hand: R L      |         | Near Vision        | J-                                          | J-                | J-    | J-              |  |

|                                                                        | Normal | Abnormal | Comments |
|------------------------------------------------------------------------|--------|----------|----------|
| <b>General Appearance</b>                                              |        |          |          |
| <b>Skin</b>                                                            |        |          |          |
| <b>Eyes:</b><br>PERRLA<br>Sclera<br>Conjunctiva<br>Fundoscopic<br>EOMS |        |          |          |
| <b>Ears:</b><br>Auditory Canal<br>Tympanic membranes<br>Fluid          |        |          |          |
| <b>Nose:</b><br>Septum<br>Mucosa                                       |        |          |          |
| <b>Mouth:</b><br>Pharynx<br>Tonsils<br>Teeth and Gums                  |        |          |          |
| <b>Neck:</b><br>Thyroid<br>Lymphadenopathy<br>ROM<br>Tenderness        |        |          |          |
| <b>Lungs:</b><br>Acultation                                            |        |          |          |
| <b>Heart:</b><br>Rhythm<br>Murmur                                      |        |          |          |

|                                                                                                                                               |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| <b>Breasts</b>                                                                                                                                |  |  |  |
| <b>Abdomen:</b><br>Bowel sounds<br>Tenderness<br>Masses<br>Organomegaly                                                                       |  |  |  |
| <b>Genitalia:</b><br>Hernia<br>Prostate<br>Rectal                                                                                             |  |  |  |
| <b>Upper Extremities:</b><br>Range of Motion<br>Muscle Strength<br>Tinel's<br>Phalen's<br>Finkelstein's                                       |  |  |  |
| <b>Lower Extremities:</b><br>Range of Motion<br>Muscle strength                                                                               |  |  |  |
| <b>Back:</b><br>Gait<br>Heel walking<br>Toe walking<br>Deformities<br>Tenderness<br>Range of Motion<br>Deep knee bend<br>Straight leg raising |  |  |  |
| <b>Neurological:</b><br>CN II-XII<br>Reflexes<br>Romberg                                                                                      |  |  |  |

**Summary of findings/additional comments:**

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**Recommendations:**

**Comments**

\_\_\_ Able to work without restrictions \_\_\_\_\_

\_\_\_ Able to work with restrictions \_\_\_\_\_

\_\_\_ Able to work with accommodations \_\_\_\_\_

\_\_\_ Medical hold pending further evaluation \_\_\_\_\_

**Examining Health Care Provider:**

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Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY AN  
OCCUPATIONAL MEDICINE HEALTH CARE PROVIDER**

|                           | <b>Hep B</b> | <b>PPD</b> | <b>MMR</b> | <b>Rubeola</b> | <b>Varicella</b> | <b>CXR</b> | <b>Hep A</b> |
|---------------------------|--------------|------------|------------|----------------|------------------|------------|--------------|
| <b>Records Pending</b>    |              |            |            |                |                  |            |              |
| <b>Given in OM - DHMC</b> |              |            |            |                |                  |            |              |
| <b>Documents Provided</b> |              |            |            |                |                  |            |              |
| <b>NA/Waived</b>          |              |            |            |                |                  |            |              |

**Lab Tests ordered:** \_\_\_\_\_ Hep B s AB \_\_\_\_\_ Rubella \_\_\_\_\_ Rubeola \_\_\_\_\_ Varicella

**PPD placed:** \_\_\_\_\_ Read \_\_\_\_\_ Results in mm \_\_\_\_\_