Employee Health Services
Pre-Placement Medical Questionnaire

Employee Health Services Hours

Monday through Friday
7:30 am to 12 noon and 1:00 pm to 4:00 pm
(closed from 12:00 noon to 1:00 pm)

637 S. Lucas Ave, Ground Floor
Los Angeles, CA 90017

213.977.2395 Phone / 213.977.2026 Fax

- Please complete this questionnaire prior to your appointment time. Be sure to bring any information regarding your vaccination history and TB screenings to the appointment.
- Please do not bring children to your appointment. This may delay the process as your appointment may need to be rescheduled.
- Applicant does not need to fast for blood work.
- The process takes 1½ - 2 hours (sometimes less).
- You are scheduled to begin your Pre-Placement Physical on:

Date: _____ Appointment Time: _____

In order to expedite the processing of your pre-placement physical health examination, please bring the following documents with you to the Employee Health Office at the time of your Pre-placement Physical Exam appointment. If you fail to bring a copy of your lab test results and documents on the day of your physical exam, you will be required to take the lab test at Good Samaritan Hospital. Read the questionnaire and answer all required fields unless otherwise noted. Please direct any questions or documents to **Employee Health Services (213) 977-2395 / Fax (213) 977-2026.**

I. Previous Physical Exam results within past 12 months (if available).

II. Previous Lab Test Results for the following titers and/or vaccination dates:

1. **Hepatitis B** (vaccination dates and titers)
2. **MMR (Measles, Mumps, Rubella)**
   Documentation of positive blood titer or two (2) doses of MMR vaccine
3. **Varicella** (Chickenpox)
   Documentation of positive Varicella blood titer or two (2) doses of Varicella vaccine
4. **Tdap (Tetanus / Diphtheria / Pertussis) vaccine**
   Documenation of vaccination required for staff working in departments caring for children under 12 months (OB, NICU, L&D, Nursery, ER, Child Care)
5. **Td (Tetanus / Diptheria)**
   Submit records of vaccination if available.

III. TB (Tuberculosis) Screening:

1. **Two TB Skin tests or two Quantiferon-TB Gold tests** (2-step method): Bring the following documentation:
   - TB test **within 1 month** of physical exam date will be accepted as the current TB Screening #1.
   - TB skin test within the last year will be accepted as TB Screening #2.
   - If you do not have documentation of a TB test within 1 month and another within 1year, you will be given a TB Skin Test at the time of your physical exam and a 2nd TB skin test within the following 1-3 weeks.
2. **Previous Positive TB Test**: if you cannot provide proper documentation of a positive TB Test, a TB skin test will be required. Proper documentation of a skin test includes dates given and read, and millimeters of induration. Quantiferon-TB Gold result and documentation of treatment for Tuberculosis infection will also be accepted.
3. **Chest X-ray** will be required for all positive TB tests unless you can provide a negative CXR done within the past **6 months and after the positive TB test.** (CXR does not replace the requirement of Positive TB test documentation).

Demographics (please print clearly)

LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER	TODAY'S DATE
DEPARTMENT	JOB TITLE	EXPECTED ORIENTATION DATE
BIRTHDATE	HOME TELEPHONE NUMBER	CELL PHONE NUMBER
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE NUMBER:	
NAME OF PRIMARY DOCTOR:	PRIMARY DOCTOR'S OFFICE NUMBER:	
HOME ADDRESS		E-MAIL ADDRESS

I have read the above pre-placement medical requirements and agree to abide by Good Samaritan Hospital policies.

_____ _____

Employee Signature **Date**

EMPLOYEE HEALTH SERVICES
Phone: (213) 977-2395 / FAX: (213) 977-2026

FULL NAME: _____ JOB TITLE: _____ DEPT NAME: _____ EXT # _____

Does your job require you to wear a TB mask? ☐ Yes ☐ No If yes, have you been Fit Tested this year? ☐ Yes ☐ No

Section I – SYMPTOM REVIEW

A. DO YOU CURRENTLY HAVE SYMPTOMS OF:

1.	**Unusual fatigue or loss of appetite for more than 2 weeks?**	☐ **Yes**	☐ **No**
2.	**Weight loss unrelated to dieting (8 lbs. or more)?**	☐ **Yes**	☐ **No**
3.	**Persistent cough and/or blood-streaked sputum for more than 3 weeks?**	☐ **Yes**	☐ **No**
4.	**Fever associated with night sweats and cough for more than 1 week?**	☐ **Yes**	☐ **No**
5.	**Other unusual symptoms?**	☐ **Yes**	☐ **No**

B. HISTORY

1.	**Have you received the measles vaccine within the last 4 weeks?**	☐ **Yes**	☐ **No**
2.	**Are you taking cortisone / steroid medications, chemotherapy or radiation therapy at this time?**	☐ **Yes**	☐ **No**
3.	**Have you ever received a BCG Vaccination?**	☐ **Yes**	☐ **No**
	**** BCG is a vaccine against Tuberculosis given in some countries where rates of Tuberculosis are high. It is not given in the United States. History of BCG does <u>not</u> prohibit skin testing.***		
4.	**Have you ever had a positive TB skin test or Quantiferon-TB Gold?**	☐ **Yes**	☐ **No**
	If yes, date of positive test: _____/_____/_____		
5.	**Have you ever received INH (Isoniazid)?**	☐ **Yes**	☐ **No**
	**** INH is medication given for treatment or prevention of Tuberculosis***		
6.	**Have you traveled outside the United States during the past year?**	☐ **Yes**	☐ **No**
	If so, where and how long: _____		
7.	**Have you knowingly been exposed to an individual with active TB?**	☐ **Yes**	☐ **No**
	If yes, what were the circumstances? _____		

(Office Use Only) **<u>TB SKIN TEST RECORD</u>** **(Office Use Only)**

<u>PPD SKIN TEST #1</u>

Date of placement: _____ R arm L arm
Placed by: _____
5 TU Lot # _____ Exp. Date: _____
Date of measurement: _____ Induration: _____mm
Erythema present Yes ☐ No ☐
Read by: _____ Employee ID # _____
Interpretation: ( ) Negative ( ) Positive ( ) Inconclusive
Interpretation by EHS: _____

<u>PPD SKIN TEST #2</u>

Date of placement: _____ R arm L arm
Placed by: _____
5 TU Lot # _____ Exp. Date: _____
Date of measurement: _____ Induration: _____mm
Erythema present Yes ☐ No ☐
Read by: _____ Employee ID # _____
Interpretation: ( ) Negative ( ) Positive ( ) Inconclusive
Interpretation by EHS: _____

MEASUREMENT OF SKIN TEST must be done <u>48 to 72</u> hours after administration

☐ **Check X-Ray Required**

Date Done: _____/_____/_____ Results: _____

Comments: _____

☐ **Cleared by: _____RN** **Date**: _____/_____/_____
Employee Health Nurse

FULL NAME: _____ DATE: _____

Please answer every question. A "Yes" or "No" must be checked for each item. You must explain all "Yes" answers on the following pages. The purpose of this information is to assure you are physically able to perform the job, which you have been offered. It may also be used to respond to any health emergencies you might have at work. Limitations or restrictions may be given if conditions are identified which could endanger your health and safety or that of another.

Do you have or have you ever had in the past any of the following:

		YES	NO
	EYES, EARS, NOSE, THROAT		
1.	Wear glasses/contacts	☐	☐
2.	Color Vision Impairment	☐	☐
3.	Hearing Loss	☐	☐
4.	Frequent sore throats	☐	☐
5.	Blurred vision	☐	☐
6.	Other	☐	☐
	PULMONARY		
7.	Asthma or emphysema	☐	☐
8.	Shortness of breath	☐	☐
9.	Chronic or frequent cough	☐	☐
10.	Tuberculosis	☐	☐
11.	Coughing blood	☐	☐
12.	Other	☐	☐
	GENITO-URINARY		
13.	Kidney or Bladder disease	☐	☐
14.	Prostatitis	☐	☐
15.	Other	☐	☐
	GASTROINTESTINAL		
16.	Diarrhea or Colitis	☐	☐
17.	Hemorrhoids or Hernia	☐	☐
18.	Hepatitis A/ B / C	☐	☐
19.	Elevated Liver Enzymes	☐	☐
20.	Other	☐	☐
	HEART/VASCULAR		
21.	Heart Attack or Stroke	☐	☐
22.	Irregular Heart Beat	☐	☐
23.	Chest Pain	☐	☐
24.	High Blood Pressure	☐	☐
25.	Leg pain while walking	☐	☐
26.	Other	☐	☐

		YES	NO
	MUSCULO/SKELETAL		
27.	Back Injury / Pain	☐	☐
28.	Neck Injury / Pain	☐	☐
29.	Shoulder Injury / Pain	☐	☐
30.	Wrist or Hand Injury / Pain	☐	☐
31.	Knee, Ankle, Foot Injury / Pain	☐	☐
32.	Joint swelling or pain	☐	☐
33.	Other fractures / broken bones	☐	☐
34.	Other	☐	☐
	CENTRAL NERVOUS SYSTEM		
35.	Headaches	☐	☐
36.	Seizures	☐	☐
37.	Dizziness	☐	☐
38.	Tremors	☐	☐
39.	Panic attacks	☐	☐
40.	Chronic Muscular Problems	☐	☐
41.	Chronic Neurological Problems	☐	☐
42.	Other	☐	☐
	MISCELLANOUS		
43.	Drug or Alcohol treatment	☐	☐
44.	Immune system impairment	☐	☐
45.	Diabetes	☐	☐
46.	Thyroid trouble	☐	☐
47.	Skin rashes / eczema / dermatitis	☐	☐
48.	Anemia	☐	☐
49.	Chemical sensitivities	☐	☐
48.	Claustrophobia	☐	☐
50.	Other	☐	☐
	Allergies		
51.	Food	☐	☐
52.	Latex / Rubber	☐	☐
53.	Medications	☐	☐
54.	Other	☐	☐

55. Are you taking any medications presently (over-the-counter and prescription)? _____

Please list: _____

56. Do you have any medical problems or limitations that might affect your ability to perform the essential functions of your job?_____

If Yes, please explain: _____

57. Do you have any work restrictions? _____ If yes, You will need to provide a copy of all work restrictions from your health care provider Please list work restrictions:_____

SUPPLEMENTAL INFORMATION

If you have answered "yes" to any questions, please provide detailed information in the space below.

QUESTION NUMBER	

58. Do you currently smoke tobacco? _____ If you smoke cigarettes, how many packs per day? _____

    Good Samaritan Hospital is a smoke-free campus. Would you like information on how quit smoking? _____

59. Do you currently have a permanent or temporary disability that may require an accommodation to perform your essential job functions? ___

    If yes, please explain: _____

60. Surgeries: List surgeries you have had in the past:

    Date: _____ Surgery: _____

    Date: _____ Surgery: _____

    Date: _____ Surgery: _____

I hereby authorize the performance of a medical examination, urine drug screening, x-rays and blood testing as required.

Good Samaritan Hospital (GSH) complies with the American with Disabilities Act and will consider reasonable accommodation for disabilities.

I understand that any misrepresentations herein may be cause for dismissal and that I must pass a physical examination and a urine drug screen test as conditions of employment. I further understand that refusal to comply with the requirements of the physical exam and drug screening process shall be considered as failure.

I understand that all medical information obtained for the pre-placement evaluation is confidential. I understand that, when records are requested for clearance, no clearance will be given until the records have been received and reviewed by the examining physician or his designee.

SIGNATURE	DATE

In the interest of the health and safety of all employees and patients, and to safeguard the legitimate interest of the **Good Samaritan Hospital**, a medical evaluation of all candidates is required. This evaluation includes a screening test to detect the illegal use of drugs and/or the abuse of alcohol. All candidates are required to undergo a screening test which involves submitting a urine sample for testing. ***A sufficient sample must be provided for testing upon receiving and signing this form or before leaving the hospital facility premises. Each step of the collection procedure must be complied with, or it will be considered a refusal to test.***

The results of this screening test will be used to determine medical fitness for employment. Failure or refusal to be tested may result in the termination of any further employment. All candidates who consent to drug/alcohol testing will be informed only whether they passed or failed the test. The results of this test are final. No additional confirming tests will be performed.

To assist us in the proper analysis of your specimen, please answer the following questions:

1. Have you taken any medication/drugs in the past two (2) weeks? ❒ Yes ❒ No
2. Are you taking any medication prescribed by a physician? ❒ Yes ❒ No
3. Have you taken over-the-counter, non prescription medication in the past twenty-four (24) hours? (Such as cold tablets, weight loss pills, pain medication.) ❒ Yes ❒ No
4. Have you ingested alcohol in the past twenty-four (24) hours? ❒ Yes ❒ No
5. Have you used any controlled substances in the past thirty (30) days? ❒ Yes ❒ No

If you answered YES to any of the above questions, list all drugs and/or medications, when they were taken and the amount used:

_____

_____

CONSENT

The undersigned hereby consents and agrees to give a sample of urine for drug/alcohol screening by a National Institute on Drug Abuse (NIDA) certified lab chosen by **GOOD SAMARITAN HOSPITAL.** The undersigned further agrees to comply with each request of the drug-screening process to meet Chain of Custody requirements, and authorizes the release of these drug/alcohol screening results to Employee Health Service, Vice President of Human Resources and

_____.

The undersigned understands that the Human Resource Department/Contracted Employer/Contracted School will be informed of his/her medical fitness for employment. **The undersigned further understands that additional information may be required from him/her by the Medical Review Officer in the event that the drug-test results are positive.**

The signature below acknowledges that the undersigned has read and understands the foregoing statement and has answered the above questions truthfully. The signature also acknowledges that any specimens provided are the undersigned's own. The undersigned hereby acknowledges receipt of a copy of the signed Chain of Custody form.

_____ _____ _____

Print Name Signature Date

_____

Witness

FULL NAME :_____

PART A. SECTION 1. (MANDATORY): The following information must be provided by all employees .

1. Today's date: _____ Hospital: _____
2. Name: _____
3. Age: _____
4. Sex: _____
5. Height: _____ ft _____ in
6. Weight: _____
7. Job Title: _____
8. Phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code) ( )_____-_____
9. The best time to phone you at this number: ☐ Days ☐ Evenings
10. Have you worn a respirator before If "yes" what type(s) _____

PART A. SECTION 2. (MANDATORY): Questions 1 through 9 below must be answered by every employee (please check "yes" or "no").

Yes	No	
☐	☐	**1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?**

Yes	No	**2. Have you ever had any of the following conditions? If Yes, Please explain.**
☐	☐	**a.** Seizures (fits):
☐	☐	**b.** Diabetes (sugar disease):
☐	☐	**c.** Allergic reactions that interfere with your breathing:
☐	☐	**d.** Claustrophobia (fear of closed-in places):
☐	☐	**e.** Trouble smelling odors:

Yes	No	**3. Have you ever had any of the following pulmonary or lung problems? If Yes, please explain.**
☐	☐	**a.** Asbestosis:
☐	☐	**b.** Asthma:
☐	☐	**c.** Chronic Bronchitis:
☐	☐	**d.** Emphysema:
☐	☐	**e.** Pneumonia
☐	☐	**f.** Tuberculosis:
☐	☐	**g.** Silicosis:
☐	☐	**h.** Pneumothorax (collapsed lung):
☐	☐	**i.** Lung Cancer:
☐	☐	**j.** Broken ribs:
☐	☐	**k.** Any chest injuries or surgeries:
☐	☐	**l.** Any other lung problem that you've been told about:

Please continue on next page

Yes	No		
		4.	**Do you currently have any of the following symptoms of pulmonary or lung illness? If Yes, please explain.**
☐	☐	a.	Shortness of breath
☐	☐	b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline:
☐	☐	c.	Shortness of breath when walking with other people at an ordinary pace on level ground:
☐	☐	d.	Have to stop for breath when walking at your own pace on level ground:
☐	☐	e.	Shortness of breath when washing or dressing yourself:
☐	☐	f.	Shortness of breath that interferes with your job:
☐	☐	g.	Coughing that produces phlegm (thick sputum):
☐	☐	h.	Coughing that wakes you early in the morning:
☐	☐	i.	Coughing that occurs mostly when you are lying down:
☐	☐	j.	Coughing up blood in the last month:
☐	☐	k.	Wheezing:
☐	☐	l.	Wheezing that interferes with your job:
☐	☐	m.	Chest pain when you breathe deeply:
☐	☐	n.	Any other symptoms that you think may be related to lung problems:

Yes	No		
		5.	**Have you ever had any of the following cardiovascular or heart problems? If Yes, please explain.**
☐	☐	a.	Heart attack:
☐	☐	b.	Stroke:
☐	☐	c.	Angina:
☐	☐	d.	Heart failure:
☐	☐	e.	Swelling in your legs or feet (not caused by walking):
☐	☐	f.	Heart arrhythmia (heart beating irregularly):
☐	☐	g.	High blood pressure:
☐	☐	h.	Any other heart problem that you've been told about:

Yes	No		
		6.	**Have you ever had any of the following cardiovascular or heart symptoms? If Yes, Please explain.**
☐	☐	a.	Frequent pain or tightness in your chest:
☐	☐	b.	Pain or tightness in your chest during physical activity:
☐	☐	c.	Pain or tightness in your chest that interferes with your job:
☐	☐	d.	In the past two years, have you noticed your heart skipping or missing a beat:
☐	☐	e.	Heartburn or indigestion that is not related to eating:
☐	☐	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? If Yes, please explain.**
☐	☐	a.	Breathing or lung problems:
☐	☐	b.	Heart trouble:
☐	☐	c.	Blood pressure:
☐	☐	d.	Seizures (fits):

Yes	No		
		8.	**If you've used a respirator, have you ever had any of the following problems? If Yes, please explain. (If you've never used a respirator, check the following space and go to question 9)**
☐	☐	a.	Eye irritation:
☐	☐	b.	Skin allergies or rashes:
☐	☐	c.	Anxiety:
☐	☐	d.	General weakness or fatigue:
☐	☐	e.	Any other problem that interferes with your use of a respirator:

Yes	No		
		9.	**Would you like to talk to the health care professional who will review this Questionnaire about your answers**
☐	☐		**to this questionnaire? If yes, list day phone number:_____**

_____	_____	_____	_____
Employee Signature	**Date**	**PLHCP Signature**	**Date**