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| LEGAL LAST NAME FIRST NAME MI   | TODAY’S DATEClick or tap to enter a date. |
| BIRTHDATE  | AGE (YEARS)  | LAST 4 SSN DIGITS  |
| BEST CONTACT NUMBER | EMAIL ADDRESS |
| EMPLOYER: The University of Kansas Health System [ ]  candidate [ ]  volunteer [ ]  The University of Kansas Physicians (UKP) [ ]  The University of Kansas Medical Center (KUMC) [ ]  KUMC GME (Resident/Fellow) |
| POSITION/TITLE  | DEPARTMENT |

**HEALTH HISTORY: CHECK (X) THE BOX EACH CONDITION YES (“Y”) OR NO (“N”)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Check Yes “Y” or No “N” for each** | **Y** | **N** | **Check Yes “Y” or No “N” for each** | **Y** | **N** | **Check Yes “Y” or No “N” for each** | **Y** | **N** |
| 1. FREQUENT/SEVERE HEADACHE | [ ]  | [ ]  | 21. PALPITATION/POUNDING HEART | [ ]  | [ ]  | 41. PAIN IN SHOULDER/ARM/HAND | [ ]  | [ ]  |
| 2. HEAD INJURY/CONCUSSION | [ ]  | [ ]  | 22. HIGH BLOOD PRESSURE | [ ]  | [ ]  | 42. CARPAL TUNNEL SYNDROME | [ ]  | [ ]  |
| 3. NECK INJURY/WHIPLASH | [ ]  | [ ]  | 23. HEART FAILURE | [ ]  | [ ]  | 43. TENDONITIS/BURSITIS | [ ]  | [ ]  |
| 4. RECURRENT NECK PAIN | [ ]  | [ ]  | 24. KIDNEY STONE/BLOOD IN URINE | [ ]  | [ ]  | 44. OVERUSE SYNDROMES | [ ]  | [ ]  |
| 5. DIZZINESS OR VERTIGO | [ ]  | [ ]  | 25. SUGAR/ALBUMIN IN URINE | [ ]  | [ ]  | 45. NUMBNESS OR WEAKNESS | [ ]  | [ ]  |
| 6. EPILEPSY/SEIZURES | [ ]  | [ ]  | 26. DIABETES | [ ]  | [ ]  | 46. PAIN IN HIP/KNEE/ANKLE/FOOT | [ ]  | [ ]  |
| 7. SLEEP DISORDER/PROBLEMS | [ ]  | [ ]  | 27. LIVER DISEASE/JAUNDICE | [ ]  | [ ]  | 47. HIP PROBLEMS | [ ]  | [ ]  |
| 8. VISUAL PROBLEMS | [ ]  | [ ]  | 28. CHANGE IN BOWEL HABITS | [ ]  | [ ]  | 48. KNEE PROBLEMS | [ ]  | [ ]  |
| 9. COLOR BLINDNESS | [ ]  | [ ]  | 29. RECENT GAIN/LOSS OF WEIGHT | [ ]  | [ ]  | 49. FOOT/ANKLE TROUBLE | [ ]  | [ ]  |
| 10. DOUBLE VISION OR BLINDNESS | [ ]  | [ ]  | 30. ULCERS | [ ]  | [ ]  | 50. SKIN TROUBLE, RASH OR DISEASE | [ ]  | [ ]  |
| 11. DO YOU WEAR GLASSES? | [ ]  | [ ]  | 31. ANEMIA | [ ]  | [ ]  | 51. SKIN DISORDERS | [ ]  | [ ]  |
| 12. DO YOU WEAR CONTACT LENSES? | [ ]  | [ ]  | 32. HERNIA | [ ]  | [ ]  | 52. DRAINING SORES OR WOUNDS | [ ]  | [ ]  |
| 13. DIFFICULTY HEARING | [ ]  | [ ]  | 33. BACK PROBLEMS | [ ]  | [ ]  | 53. ALLERGY TO LATEX OR RUBBER | [ ]  | [ ]  |
| 14. HEARING LOSS/HEARING AID | [ ]  | [ ]  | 34. BACK STRAIN OR INJURY | [ ]  | [ ]  | 54. RHEUMATIC FEVER | [ ]  | [ ]  |
| 15. RINGING IN EARS | [ ]  | [ ]  | 35. BULGING/HERNIATED DISKS | [ ]  | [ ]  | 55. SCARLET FEVER | [ ]  | [ ]  |
| 16. RECURRENT EAR INFECTIONS | [ ]  | [ ]  | 36. SCIATICA/PINCHED NERVE | [ ]  | [ ]  | 56. MEASLES | [ ]  | [ ]  |
| 17. SHORTNESS OF BREATH/ASTHMA | [ ]  | [ ]  | 37. BACK X-RAYS/MRI | [ ]  | [ ]  | 57. MUMPS | [ ]  | [ ]  |
| 18. RECURRENT COUGH | [ ]  | [ ]  | 38. BROKEN BONE OR BONE DISEASE | [ ]  | [ ]  | 58. RUBELLA | [ ]  | [ ]  |
| 19. HEAT OR SUN STROKE | [ ]  | [ ]  | 39. BONES OR JOINT DEFORMITY | [ ]  | [ ]  | 59. CHICKEN POX | [ ]  | [ ]  |
| 20. CHEST PAIN OR PRESSURE | [ ]  | [ ]  | 40. RHEUMATISM/ARTHRITIS | [ ]  | [ ]  | 60. SHINGLES | [ ]  | [ ]  |

**List any other chronic illness(es) or medical condition(s) not listed above in the below space or mark:** [ ]  None





**Are you taking any medications?** [ ]  No [ ]  Yes; please list medications below:



**Are you allergic to any vaccines (shots)?** [ ]  No [ ]  Yes; please explain (i.e. vaccine type, reaction description, and the date it occurred): 

**Are you allergic to any medications?** [ ]  No [ ]  Yes; please list: 

***SURGICAL HISTORY***

**Check the** [ ]  **if you have not had any surgical procedures. Or, list previous surgical procedures (types) with the procedure year below.**





***TUBERCULOSIS (TB) HISTORY***

1. Have you ever had a **positive** TB test? [ ]  No [ ]  Yes

If yes, date of the positive test  date of last chest x-ray 

Also, did you take TB medication (preventative therapy)? [ ]  No [ ]  Yes

Medication type  and duration  (*Provide all supporting documentation.*)

1. Have you lived or visited more than 1 month in a country **other than** Australia, Canada, New Zealand, the United States, and western or northern Europe? [ ]  No [ ]  Yes If yes, where? 
2. Do you currently have a (if yes, check the box) [ ]  persistent cough (3 weeks or more), [ ]  coughing-up blood, [ ]  recent fever, [ ]  night sweats, or [ ]  loss of appetite? [ ] No to all symptoms.
3. Do you currently or within the last year (*12-months*):
	1. live with someone with the above symptoms? [ ]  No [ ]  Yes
	2. been exposed to a person with known **active** TB when not wearing respiratory protection (N95 or PAPR) [ ]  No [ ]  Yes

***OCCUPATIONAL EXPOSURE HISTORY***

Have you ever had an occupational exposure to:

Blood or Body Fluid [ ]  No [ ]  Yes If yes, please explain:

Chemotherapy/Hazardous Drug [ ]  No [ ]  Yes If yes, please explain:

Chemicals [ ]  No [ ]  Yes If yes, please explain:

In the past 2 weeks, any exposures to a contagious disease, like measles, chicken pox, mumps etc.? [ ]  No [ ]  Yes

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

***RESTRICTION or LIMITATION HISTORY***

1. Have you ever had any serious injuries? [ ]  No [ ]  Yes

If yes, explain:

1. Do you have any current restrictions or limitations? [ ]  No [ ]  Yes

If yes, explain:

1. Have you ever been told you have a permanent restriction? [ ]  No [ ]  Yes

If yes, explain:

**I hereby certify that the information I have furnished on this form and to Occupational Health (OH) is true and correct. I understand that falsification or omission may result in denial of or dismissal from employment. I authorize OH to disclose any pertinent finding/s on a need to know basis to authorized individuals for use regarding my employment.**

 

 **Candidate Electronic Signature** **Date**

# Official Use Only

***REVIEWING PROVIDER COMMENTS – Refer to the Physical Exam document for additional comments***

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***REVIEWING PROVIDER SIGNATURE DATE***