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| LEGAL LAST NAME FIRST NAME MI | | | | TODAY’S DATE  Click 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***