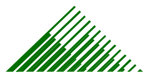
OCCUPATIONAL & ENVIRONMENTAL MEDICINE
DARTMOUTH-HITCHCOCK MEDICAL CENTER

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Pre-placement Health Questionnaire for DHMC Employees
- CONFIDENTIAL -

Purpose:

- To identify any illness of disability that may affect an employee's ability to perform the essential functions of their position with or without accommodation.
- To ensure that employees meet all DHMC 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 kept in a separate Employee Health Chart with access limited to Occupational Medicine staff and is protected by Federal and State Law.

Name:______________________________________ Age:________ Today's Date:_____________

Birth Date:____________ SS#:___________________ Home Phone:___________________________

Address:_________________________________ City:______________ State:_____ Zip:________

Department:_____________________________ Job Title:_________________________________

Please complete this questionnaire in your own writing. Misrepresentation or deliberate omission of relevant information may be grounds for termination or denial of employment. 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 your visit today is to evaluate your fitness to perform specific job tasks and to ensure the safety of yourself and others.

Work History – Employment

Previous Employer:__________________________________ Hrs worked per day/wk: _____________
Dates of Employment:___________________ Describe Job Duties:______________________________
____
____
____
____

Previous Position(s):_________________________________ Hrs worked per day/wk:_____________
Length of time at job:___________________ Describe Job Duties:______________________________
____
____
____

Work History – Exposures

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 before new assignments are made. Considering this, carefully answer the following questions. Have you ever:

☐Yes ☐No Worked with ionizing radiation or radioactive substances?

☐Yes ☐No Worked with microwaves (outside of home), lasers, or masers?

☐Yes ☐No Worked with toxic or hazardous substances such as (choose all that apply):

☐Acrylics	☐Advanced composites	☐Anesthetic agents
☐Anti-neo-plastics	☐Arsenic	☐Asbestos
☐Benzene	☐Berylium	☐Blood/body fluids
☐Cadmium	☐Coal tar derivatives	☐Ethylene Oxide
☐Formaldehyde	☐Glycol Ethers	☐Lead
☐Mercury	☐Pesticides	☐Silicates
☐Solvents	☐Other (please list all):___________________________	

☐Yes ☐No Incurred an exposure to blood or body fluids within the last 12 months? (This relates to blood or body fluid coming in contact with your open skin, eyes, nose, or mouth.)

☐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 your work involved 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?

Work History – Restrictions & Past Injuries

☐Yes ☐No Do you have any current work restrictions?
If yes, list medical provider who determined the restrictions:______________________
If yes, please describe:____
____

Some job assignments could be extremely dangerous in the event of dizziness, loss of consciousness, or loss of equilibrium. As the result of injury, do you have any impairment(s) which may:

☐Yes ☐No Affect your equilibrium or ability to maintain your balance?

☐Yes ☐No Alter your normal state of consciousness or cause you to become unconscious?

☐Yes ☐No Make it dangerous for you to work at unguarded hazardous heights or around moving machinery?

☐Yes ☐No Prohibit you from driving licensed company vehicles on public highways?

☐Yes ☐No Prohibit you from working alone in remote, isolated, or confined spaces?

☐Yes ☐No Limit your ability to perform very strenuous physical activity?

"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?
If yes, length of time away from job:______________________________________

☐Yes ☐No Filed a workers' compensation claim because of a job related injury?
If yes, date of injury:______________ Employer:_____________________________
Type of treatment(s) received: ☐PT/OT ☐Surgery ☐Other: ______________
____

☐Yes ☐No Do you have any workers' compensation claim that is still open or pending?
If yes, please describe:____

☐Yes ☐No Received a disability award or pension for a job related accident or illness?
If yes, please describe:____

Some work assignments require abilities to maintain a firm grip, to lift and carry bulky or heavy objects, to stand, walk and climb on irregular work surfaces, ladders, and scaffolding. Some work assignments may require frequent and prolonged bending of the neck and back, while others require repetitive use of the upper or lower extremities. As a result of injury, illness, or other cause, do you have any impairment of:

☐Yes ☐No Either arm or shoulder that limits normal range of motion, full use, or strength of your upper extremities?

☐Yes ☐No Either hand that limits dexterity or your ability to maintain a strong grip or hold objects firmly?

☐Yes ☐No Either foot or leg which limits normal range of motion or your ability to stand, walk, squat, kneel, climb stairs, work on ladders, or scaffolding, or walk about on slippery or uneven work surfaces?

☐Yes ☐No The neck, which interferes with bending or rotation of your neck, or which interferes with your ability to hold you head in fixed positions for prolonged periods of time?

☐Yes ☐No The back, which interferes with your ability to bend your back frequently or your ability to lift and carry heavy objects?

Comments: ____
____

Social History – Hobbies

List concurrent jobs, hobbies, sports, and home activities:____
____
____

☐Yes ☐No Do you exercise regularly (ie: running, jogging, swimming, walking aerobics, etc)?
If you play sports, please list:____

Social History – Tobacco & Nicotine Use History

☐Yes ☐No Have you ever used tobacco or nicotine products?

☐Yes ☐No Are you currently using tobacco?
If yes, how many packs/pouches/tins per day:___________ Number of years:______

Unsafe work behavior can result from drug abuse, alcohol, or psychiatric illness.

☐Yes ☐No Are you currently, or have you ever, been treated for substance abuse?
If yes, please describe:____

☐Yes ☐No Do you currently have a psychiatric disorder, such as depression or bipolar disorder?

☐Yes ☐No Do you have difficulty working due to stress, anxiety, depression, panic, and or claustrophobia?

☐Yes ☐No Are you currently receiving counseling for any of the above?
If yes, please describe:____

Social History – Females Only

☐Yes ☐No Are you currently pregnant? Expected due date:_____________________________

Date of last pap smear:__________________ Date of last mammogram (if appropriate):______________

Allergies & Medications

List any allergies you may have and the reactions you have to them:

☐ **Check here if no known allergies to medications**

Allergies	Reactions

List all current prescription medications:

Medications	Dosage	Reason

List all non-prescription (over-the-counter) medications or herbal preparations you are currently taking:

Medications/Preparations	Dosage	Reason
______________________	________	______________________
______________________	________	______________________

Allergies - Latex

Complete this section only if you are required to wear gloves in your new position.

☐Yes ☐No Are you allergic or sensitive to latex (natural rubber)?
If yes, please continue on to the next question.
If no, please skip to the next section (Health Status & History).

☐Yes ☐No Do you have any type of chronic skin condition?
If yes, please describe:______________________________

☐Yes ☐No Do cuts in your skin usually stay open a long time?

☐Yes ☐No Are you bothered by severe itching?

☐Yes ☐No Have you ever had any sensitivity to chemicals or soaps?

☐Yes ☐No Have you ever had Eczema?

☐Yes ☐No Have you been told by a health care provider that you have an allergy to latex?

☐Yes ☐No Have you been tested for a latex allergy?
If yes, was the test positive for allergy: ☐Yes ☐No

☐Yes ☐No Have you had a reaction to any of the following things within one hour of exposure?
If yes, to what specifically did the health care provider say you were allergic to (reactions may include itching, redness, swelling, hives, runny nose, congestion, wheezing, or chest tightness)?

☐Adhesive Tape ☐Balloon ☐Bandaide
☐Condom ☐Dental Dam ☐Dental Procedures
☐Face Mask ☐Gynecological Exams ☐Rubber Band
☐Others:______________________________

☐Yes ☐No Do you have personal history of any of these?

☐Asthma ☐Conjunctivitis ☐Contact Dermatitis (Rash)
☐Rhinitis (Runny Nose) ☐Throat Swelling Shut ☐Urticaria

☐Yes ☐No Do you have any food allergies?
If yes, are you allergic to any of the following (common symptoms are mouth tingling, lip swelling, itchy throat, runny nose, wheezing, itching, or nausea)?

☐Avocado ☐Banana ☐Chestnut
☐Kiwi ☐Nuts ☐Papaya
☐Passion Fruit ☐Peach ☐Tomato
☐Raw Potato ☐Other Foods:______________________

☐Yes ☐No Have you had any problems with glove use?
If yes, please describe:______________________________

Health Status & History

Indicate if you have had in the past or currently have any of the following conditions. Please describe in the space provided.

- ☐ Heart Disease: ____________
- ☐ Circulation Problems: ____________
- ☐ Lung/Breathing Problems: ____________
- ☐ Kidney Problems: ____________
- ☐ Diabetes: ____________
- ☐ Nervous System Problems: ____________
- ☐ Seizures/Epilepsy: ____________
- ☐ Surgery: ____________
- ☐ Emotional Disorder: ____________
- ☐ Hernia: ____________
- ☐ Prosthetics: ____________
- ☐ High Blood Pressure: ____________
- ☐ Stroke: ____________
- ☐ Hepatitis: ____________
- ☐ Thyroid Disease: ____________
- ☐ Low Blood Sugar: ____________
- ☐ Panic, Anxiety, or Claustrophobia: ____________
- ☐ Cancer: ____________
- ☐ Skin Allergies/Sensitivities: ____________
- ☐ Vision or Hearing Problems: ____________
- ☐ Muscular Problems: ____________
- ☐ Gastrointestinal Problems: ____________
- ☐ Genetic Disorders: ____________
- ☐ Orthopaedic Problems (pain/disorders of the back, neck, joints, etc): ____________
- ☐ Chiropractic Treatment: ____________
- ☐ Consulted a medical provider because of any muscle or bone problem in the last two years (other than previously described): ____________
- ☐ Advised to have a surgical operation which has not been performed: ____________
- ☐ Any other medical conditions: ____________

Respirator Medical Clearance --- Please read carefully

Complete this section if you will be working in a ***clinical position or employed in Housekeeping, Pharmacy, Engineering, Laboratory or Transportation**. Otherwise, please skip to the next section (Infection Control). 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 contacted.

Respirators that may be used by employees for respiratory protection at DHMC may include N95s, Tuberculosis Respirators, and Powered Air Purifying Respirators (PAPR).

Check the type of respirators you will possibly use:

☐ N, R, or P disposable respirators (filter mask, non-cartridge type only)

☐ Other types (ie: half- or full-face piece type, powered air-purifying, supplied air)

Have you worn a respirator in the past? ☐ Yes ☐ No

If yes, what types: ____________

Did you have any difficulties with respirator use: ____________

____

____

Every employee who has been selected to use any type of respirator must answer questions 1 through 9 below.

1. ☐Yes ☐No Do you currently smoke tobacco or have you smoked tobacco in the last month?
   If yes, what amount:____

2. Have you ever had any of the following conditions?
   ☐Yes ☐No Claustrophobia ☐Yes ☐No Diabetes
   ☐Yes ☐No Seizures ☐Yes ☐No Trouble smelling odors
   ☐Yes ☐No Allergic reactions that interfere with your breathing

3. Have you ever had any of the following pulmonary or lung problems?
   ☐Yes ☐No Asbestosis ☐Yes ☐No Asthma
   ☐Yes ☐No Broken Ribs ☐Yes ☐No Chest Injuries/Surgeries
   ☐Yes ☐No Chronic Bronchitis ☐Yes ☐No Emphysema
   ☐Yes ☐No Lung Cancer ☐Yes ☐No Pneumonia
   ☐Yes ☐No Pneumothorax (collapsed lung) ☐Yes ☐No Silicosis
   ☐Yes ☐No Tuberculosis ☐Yes ☐No Any other lung problems:_________

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

5. Have you ever had any of the following cardiovascular or heart problems?
   ☐Yes ☐No Heart Attack ☐Yes ☐No Swelling in your legs or feet
   ☐Yes ☐No Stroke ☐Yes ☐No Heart Arrhythmia (irregular heart beat)
   ☐Yes ☐No Angina ☐Yes ☐No Heart Failure
   ☐Yes ☐No High Blood Pressure
   ☐Yes ☐No Any other heart problems you've been told you have:______________________

6. Have you ever had any of the following cardiovascular or heart symptoms?
   ☐Yes ☐No Frequent pain or tightness in your chest
   ☐Yes ☐No Pain or tightness in your chest during physical activity
   ☐Yes ☐No Pain or tightness in your chest that interferes with your job
   ☐Yes ☐No In the past two years, have you noticed your heart skipping or missing a beat
   ☐Yes ☐No Heartburn or indigestion that is not related to eating
   ☐Yes ☐No Any other symptoms that you think may be related to heart or circulation problems.

If yes, please describe:____

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

☐Yes ☐No Breathing or Lung Problems ☐Yes ☐No Heart Trouble
☐Yes ☐No Blood Pressure ☐Yes ☐No Seizures

If you answered yes to any of the options for question 7, 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.) ☐

☐Yes ☐No Anxiety ☐Yes ☐No Eye Irritation
☐Yes ☐No General Weakness or Fatigue ☐Yes ☐No Skin Allergies or Rashes
☐Yes ☐No Any other problem that interferes with your use of a respirator

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

Infection Control

DHMC Infection Control Policy requires all staff, who provide direct patient care and/or work in patient care areas, to be immune to measles (rubeola), German measles (rubella), chickenpox (varicella), and Hepatitis-B. If documentation of disease, blood test results, or immunization records is not provided, testing will be needed to establish immunity. By providing this documentation you help us to conserve resources and avoid repeating these tests. Please attach copies of vaccination history and/or serological (lab) testing and complete the following section.

Have you ever had any of the following childhood diseases and/or immunizations?

☐Yes ☐No Mumps Dates:_____________

☐Yes ☐No DPT / Tdap Dates:_____________

☐Yes ☐No Tetanus Booster Dates:_____________

☐Yes ☐No Measles (Rubeola)* Dates:_____________

☐Yes ☐No German Measles (Rubella)* Dates:_____________

☐Yes ☐No Chickenpox (Varicella)* Dates:_____________

☐Yes ☐No Hepatitis B (3-Dose Series)* Dates:_________(1st) ________(2nd) _________(3rd)

All staff are required to participate in the DHMC Tuberculosis Surveillance Program, which includes baseline TB PPD skin testing or completion of annual symptom questionnaire if history of previous positive TB test.

Date of most recent TB (PPD) Skin Test*:________________________
Result of that test: ☐Negative ☐Positive
Have you previously had a positive TB skin test? ☐Yes ☐No
If yes, please answer the following:
Date of test: ____________
Did you receive medication(s): ____

When was your most recent chest X-ray (if applicable):____________________

I have answered the questions to the best of my knowledge. I understand that this questionnaire is to assist the Occupational Medicine staff in determining my medical suitability to safely perform the functions of this position for which I have applied at DHMC.

I believe I can perform those functions in a safe manner. ***YES*** ☐ ***NO*** ☐

If NO, please explain: ____

I understand that deliberate falsification of information on this form may be reason for disciplinary actions up to and including termination.

____ ___________________________

Applicant Signature Today's Date

****

To be completed by OM Staff:

Summary of findings/additional comments: ____

____

____

____

Recommendations **Comments**

☐ Able to work without / with restrictions / accommodations

☐ **Medical hold pending further evaluation and requested from treating provider**: ______________

____

☐ Not cleared pending OM Provider visit: ____

Titers Drawn

☐ Hep B
☐ Rubella
☐ Rubeola
☐ Varicella
☐ Mumps

TB

☐ PPD planted ________ Due at GO __________
☐ Two step required – 2nd step due ____________
☐ CXR (PA only) if greater than 1 year

☐ Questionnaire completed
☐ OM Provider visit required
☐ LTBI Therapy Date:_________ Length tx:________

☐ **Tdap status** ☐ Up to date ☐ given ______________________

Date of General Orientation ________________

____ __________________

Occupational Medicine Date