COFFEE REGIONAL MEDICAL CENTER
PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE
EMPLOYEE SCREENING

Name: ______________________________ Job Applied For: ______________________________

Address: ______________________________ Department: ______________________________

City: ____________________ State: ____________________ Zip: ____________________

Home Telephone: ______________ SSN: ______________ Date of Birth: ____________ Age: ______ Sex: ______

Personal Physician: ____

Notify in Case of Emergency: ____

Relationship: ______________________________ Home Phone: ______________________________

PAST MEDICAL HISTORY

ILLNESSES – Check YES or NO. If YES, indicate the year in which the condition occurred.

ILLNESS	YES	YEAR	NO	ILLNESS	YES	YEAR	NO
01. AIDS	☐		☐	45. HERNIA	☐		☐
02. ALLERGIES	☐		☐	46. HIGH BLOOD PRESSURE	☐		☐
03. ANEMIA	☐		☐	47. HIV	☐		☐
04. ANGINA	☐		☐	48. HODGKIN'S DISEASE	☐		☐
05. ANKYLOSIS OF JOINT	☐		☐	49. HYPERINSULINISM	☐		☐
06. ANY AMPUTATIONS	☐		☐	50. IONIZING RADIATION INJURY	☐		☐
07. ARTERIOSCLEROSIS	☐		☐	51. JAUNDICE	☐		☐
08. ARTHRITIS	☐		☐	52. KIDNEY CONDITIONS	☐		☐
09. ASTHMA	☐		☐	53. LIVER/GALL BLADDER	☐		☐
10. BACK PROBLEMS	☐		☐	54. LOSS OF SIGHT	☐		☐
11. BLOOD CLOT	☐		☐	55. LOW BACK PAIN	☐		☐
12. BLOOD DISEASE	☐		☐	56. MEASLES	☐		☐
13. BONE JOINT PROBLEMS	☐		☐	57. MENTAL RETARDATION	☐		☐
14. BOWEL IRREGULARITIES (DIARRHEA, CONSTIPATION)	☐		☐	58. MULTIPLE SCLEROSIS	☐		☐
15. BRAIN DAMAGE	☐		☐	59. MUMPS	☐		☐
16. BREAST LUMPS	☐		☐	60. MUSCULAR DYSTROPHY	☐		☐
17. BRONCHITIS	☐		☐	61. OSTEOMYELITIS	☐		☐
18. BURSITIS	☐		☐	62. PARKINSON'S DISEASE	☐		☐
19. CANCER	☐		☐	63. PEPTIC ULCER	☐		☐
20. CEREBRAL PALSY	☐		☐	64. PNEUMONIA	☐		☐
21. CEREBRAL VASCULAR ACCIDENT	☐		☐	65. POLIOMYELITIS	☐		☐
22. CHICKENPOX	☐		☐	66. PROSTATE (MALES)	☐		☐
23. CHRONIC COUGH	☐		☐	67. PSYCHOLOGICAL PROBLEMS	☐		☐
24. COLDS (FREQUENT)	☐		☐	68. PHEUMATIC FEVER	☐		☐
25. COLITIS	☐		☐	69. PULMONARY DISEASE	☐		☐
26. COMPRESSED AIRE SEQUELAE	☐		☐	70. RUPTURED INTERVERTEBRAL DISC	☐		☐
27. DEPRESSION/EMOTIONAL PROBLEMS	☐		☐	71. SERIOUS DENTAL DISORDERS	☐		☐
28. DEAFNESS	☐		☐	72. SEVERE WEAKNESS OR TIREDNESS	☐		☐
29. DIABETES	☐		☐	73. SHORTNESS OF BREATH	☐		☐
30. EAR PROBLEMS	☐		☐	74. SICKLE CELL ANEMIA	☐		☐
31. EMPHYSEMA	☐		☐	75. SILICOSIS	☐		☐
32. EPILEPSY	☐		☐	76. SINUS PROBLEMS	☐		☐
33. EYE PROBLEMS (GLAUCOMA/CATARACT/COLOR BLIND)	☐		☐	77. SOAKING NIGHT SWEATS	☐		☐
34. FAINTING OR DIZZY SPELLS	☐		☐	78. SORE IN MOUTH THAT HEALED POORLY	☐		☐
35. FOOT PROBLEMS	☐		☐	79. SKIN RASH OR INFECTIONS	☐		☐
36. FRACTURES (BROKEN BONES)	☐		☐	80. SORE THROATS (FREQUENT)	☐		☐
37. GONORRHEA, SYPHILIS	☐		☐	81. STROKE	☐		☐
38. GOUT	☐		☐	82. SWELLING OF LEGS AND ANKLES	☐		☐
39. HAYFEVER	☐		☐	83. THROMBOPHLEBITIS	☐		☐
40. HEADACHES (FREQUENT)	☐		☐	84. TUBERCULOSIS	☐		☐
41. HEART DISEASE	☐		☐	85. ULCERS	☐		☐
42. HEAVY METAL POISONING	☐		☐	86. VARICOSE VEINS	☐		☐
43. HEMOPHILIA	☐		☐	87. WEAR GLASSES OR CONTACTS	☐		☐
44. HEPATITIS	☐		☐	88. WEIGHT PROBLEMS, CHANGES	☐		☐

1. List any conditions which you have that is not listed previously: ______________________

____

2. Are you receiving medical treatment at this time? ☐ Yes ☐ No If yes, give reason: ______________________

____

____

____

Physician in charge: ______________________

3. Have you ever been injured on your job? ☐ Yes ☐ No

Who was your employer and what is the approximate date of the injury? ______________________

(a.) Name and address of physician: ______________________

(b.) What part of your body was injured? ______________________

(c.) Did you receive Workers Compensation benefits? ______________________

(d.) Did you receive any permanent restrictions/disability? ______________________

4. Have you ever had any problems with your back? ☐ Yes ☐ No If yes, give the date and details (include names of treating physicians):

____

____

5. Are you a smoker? ☐ Yes ☐ No Year Began: __________ Frequency: ______________________

Would you like to stop smoking? ☐ Yes ☐ No

6. What is your pattern of alcohol use? ☐ Daily ☐ Weekends ☐ Occasional ☐ Abstinent

7. HOSPITALIZATIONS AND OPERATIONS – (EXAMPLE: 1980 Appendectomy)

1. ______________________
2. ______________________
3. ______________________
4. ______________________

(Rev. 03/10/11-BLG)

COFFEE REGIONAL MEDICAL CENTER
PRE-EMPLOYMENT LATEX SENSITIVITY QUESTIONNAIRE

Name: ______________________________ Department: ______________________________

1. Do you have any allergies (medication or food)? ☐ Yes ☐ No

   If yes, explain: ______________________________

2. Have you ever suffered from:

   Allergic Rhinitis (runny nose)? ☐ Yes ☐ No

   If yes, explain: ______________________________

   Allergic Conjunctivitis (red, watery eyes)? ☐ Yes ☐ No

   If yes, explain: ______________________________

   Asthma? ☐ Yes ☐ No

   If yes, explain: ______________________________

   Difficulty Breathing (wheezing)? ☐ Yes ☐ No

   If yes, explain: ______________________________

   Eczema? ☐ Yes ☐ No

   If yes, explain: ______________________________

   Hay Fever or Seasonal Allergies? ☐ Yes ☐ No

   If yes, explain: ______________________________

   Hives? ☐ Yes ☐ No

   If yes, explain: ______________________________

   Sinus Problems? ☐ Yes ☐ No

   If yes, explain: ______________________________

3. Do you take any allergy medications, including inhalers? ☐ Yes ☐ No

4. Have you ever had any skin rashes or breathing problems after handling or being exposed to the following?

   - Gloves (latex/vinyl) ☐ Yes ☐ No
   - Band-aids ☐ Yes ☐ No
   - Balloons, Condoms or other Rubber Products ☐ Yes ☐ No
   - Bananas, Kiwi, Papaya, Chestnuts, Avocado, Passion Fruit, Potato, Tomato, Peaches or any other Tropical Fruits ☐ Yes ☐ No
   - Dental, Surgical or Gynecology Visits ☐ Yes ☐ No

Candidate Signature: ______________________________ Date: ______________

Employee Health Signature: ______________________________ Date: ______________

(Rev. 08/25/07-BLG)

COFFEE REGIONAL MEDICAL CENTER
PRE-EMPLOYMENT LATEX SENSITIVITY QUESTIONNAIRE
Addendum to Page 1

Name: ______________________ Department: ______________________

Occupation: ______________________ # of Years in Occupation: ______________

Allergies: ____

Current Medications: ______________________________________

Past Medications: ____

1. Have you ever been told by a doctor that you have an allergy to a latex product? ☐ Yes ☐ No

   If yes, what specifically did the doctor say you were allergic to? ______________________

   ____

2. Do you have any history of: ☐ Contact Dermatitis ☐ Rhinitis or Conjunctivitis

   ☐ Asthma ☐ Eczema ☐ Auto-Immune Disease ☐ Hay Fever

3. Please check product(s) to which you have noted a reaction:

   ☐ Surgical gloves ☐ Enema cuffs ☐ Elastic threads ☐ Tubing (latex ports)
   ☐ Catheters ☐ Dental dams ☐ Balloons ☐ Rubber bands/binders
   ☐ Buretrols ☐ Condoms ☐ Ostomy bags ☐ Anesthetic masks
   ☐ Diaphragms ☐ Elastic adhesives (Bandaids) ☐ Rebreather bags ☐ Intestinal tubes
   ☐ Intubation tubes ☐ Ostomy tubes ☐ Vials with latex tops ☐ Powder in latex gloves
   ☐ Stomach tubes ☐ Other: ______________________

4. Type of reaction noted:

   ☐ Sneezing ☐ Itching skin ☐ Chapped or cracking hands ☐ Low blood pressure
   ☐ Stuffy nose ☐ Itching throat ☐ Shortness of breath ☐ Loss of consciousness
   ☐ Runny nose ☐ Itching ears ☐ Wheezing ☐ Other: ______________
   ☐ Watery eyes ☐ Itching eyes ☐ Tight chest ______________

5. Do you have any food allergies? ☐ Yes ☐ No

   If yes, are you allergic to any of the following?

   ☐ Kiwi ☐ Banana ☐ Potato ☐ Milk ☐ Papaya ☐ Peaches
   ☐ Avocado ☐ Passion Fruit ☐ Tomato ☐ Chestnuts ☐ Other: ______________

6. Have you had any previous surgery? ☐ Yes ☐ No

   If yes, how many? ______________________________________

   If yes, what types? _____________________________________

7. Have you ever had any allergic symptoms following a dental or gynecologic exam? ☐ Yes ☐ No

   If yes, explain: ____

8. Have you ever had an anaphylactic reaction to latex products or devices? ☐ Yes ☐ No

   If yes, explain: ____

Candidate Signature: ______________________ Date: ______________

Employee Health Signature: ______________________ Date: ______________

COFFEE REGIONAL
MEDICAL CENTER

EMPLOYEE HEALTH DEPARTMENT

Fax #: 912-383-6927 Ext: 5939 or 6939

TUBERCULOSIS SKIN TEST FORM

______________________ received a TST at Coffee Regional Medical Center.

Date: ____________ on the ☐ LFA ☐ RFA Administered by: ____________

Lot #: ______________________ Expiration Date: ____________

Results read on: ______________________

Results/MM: ____________ Date: ____________ Read by: ____________

TB MASK-FIT TESTING

Employee: ______________________

Department: ______________________

Date: ______________________

Style: ______________________

Size: ______________________

I have been fit-tested with the Hepa TB Mask by:

______________________ , Employee Health

(Rev. 04/29/10 BLG)

COFFEE REGIONAL MEDICAL CENTER
HEPATITIS B IMMUNIZATION
EMPLOYEE CONSENT FORM

I understand that due to my occupational exposure to blood or other potentially infectious materials (body fluids), I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no cost to myself and I have received a copy of the Hepatitis B information sheet. I have been explained the information and certify that I understand the contents of the Hepatitis B information sheet and it has been explained that:

1. I may request HBV antibody testing prior to deciding whether or not to receive the Hepatitis B vaccination.

2. If I am found to be immune to HBV by virtue of adequate antibody titer, then my employer is not required to offer me the HBV vaccine, and

3. Should I decline the offer to receive the HBV vaccination, and at a later date decide to accept the HBV vaccination, I may do so at that time as long as I am employed at Coffee Regional Medical Center and at no cost to myself.

I have been instructed that as a result of this vaccination, I may experience some side effects such as:

Soreness at the injection site	Joint pain	Headache
Weakness	Redness, tenderness or swelling	Dizziness
Fever	Rash	

I have received the vaccination at: ______________________________

I hereby ☐ ACCEPT ☐ DECLINE the Hepatitis B vaccine.

______________________________ ______________________________
Employee Signature Date

____
Social Security Number

I certify that the above named employee received a copy of the Hepatitis B information sheet and has been fully explained the contents thereof. I further certify that I reviewed with the above name employee our established Hepatitis B immunization policy and procedure.

______________________________ ______________________________
Signature Date

____
Title

(Rev. 08/09/07-BLG)

COFFEE REGIONAL
MEDICAL CENTER

EMPLOYEE HEALTH PROFILE

Employee: ______________________ Department: ______________________

☐ Hep-R
☐ PSA (Age 50)
☐ Thyroid (Age 40)

☐ Hepatitis B Vaccine (Had Series) Immune? ☐ Yes ☐ No
☐ Declined Hepatitis B Vaccine (Declination Signed)
☐ Hepatitis B Titer Drawn

☐ TB Skin Test (PPD) Date: ________________ Results: ______________
☐ Left Arm ☐ Right Arm Lot #: ______________________

☐ 2nd PPD (2 Step)
☐ Previous Positive
☐ Chest X-Ray ______________________
☐ Follow-up Skin Test Conversion: Date: ________________

☐ MMR ☐ Born Before 1957
☐ Adult Tetanus Toxoid Booster (Every 10 Years)
☐ Immunization Record
☐ TB Mask Fit Test Style/Size: ______________________ ☐ N/A
☐ Mask Education Date: ________________ Initials: __________
☐ Color Blindness Test ☐ Pass ☐ Fail

Optional

☐ Mammogram (Age 40)
☐ EKG (Age 40)

Height: __________ Weight: __________ BP: __________ Pulse: __________

Comments: ____

____

____

______________________________ ______________
Employee Health Signature Date

(Rev. 01/29/10 – BLG)

COFFEE REGIONAL MEDICAL CENTER

EMPLOYEE HEALTH DEPARTMENT

Employee: ____________________ Department: ____________________

SSN: ____________________ Birthdate: ____________________

IMMUNIZATIONS

	Date		Date
PPD	____________	PPD	____________
PPD	____________	PPD	____________
FLU	____________	FLU	____________
FLU	____________	FLU	____________
Tetanus	____________	Tetanus	____________
Tetanus	____________	Tetanus	____________
Hepatitis	____________	Hepatitis	____________
Hepatitis	____________	Hepatitis	____________
MMR	____________	MMR	____________
Varicella	____________	Varicella	____________

COFFEE REGIONAL MEDICAL CENTER
EMPLOYEE DRUG USAGE INFORMATION

PRESCRIBED DRUGS	RECREATIONAL DRUGS	SOCIAL DRUGS (EX: ALCOHOL, BEER, ETC.)	OVER-THE-COUNTER DRUGS

EMPLOYEE SIGNATURE: **DATE:**

EMPLOYEE HEALTH NURSE: **DATE:**

(Rev. 08/03/07 -- BLG)

COFFEE REGIONAL
MEDICAL CENTER

EMPLOYEE HEALTH DEPARTMENT

EMPLOYEE HEALTH SCREENING COMPLETION

To: Human Resources Department

From: Employee Health Department

Re: Employee Health Screening

☐ Pre-Employment

☐ Annual

Employee Name: ______________________

Employee Social Security #: ______________________

Department: ______________________

TB Screen Complete: ______________________

Immunization Record: ______________________

Date Completed: ______________________

REPORT TO HUMAN RESOURCES FOR FURTHER INSTRUCTION ON PRE-EMPLOYMENT REQUIREMENTS.

____

Employee Health Signature

(Rev. 01/29/10 – BLG)