



**OCCUPATIONAL HEALTH SERVICE
PRE-PLACEMENT HEALTH ASSESSMENT**

Last Name	First Name	Initial	Hire Date	Birth Date	Sex M F
Address		City/State	Zip	Phone	
Emergency Contact			Phone		
Job Title	Division / Department	Social Security Number			
Family Physician					
Are you taking medications regularly? Y N If yes, list.					
ALLERGIES No Yes (List):					
MEDICAL HISTORY Check if you have had any of the following:					
1 <input type="checkbox"/> Vision problems	11 <input type="checkbox"/> Diabetes	21 <input type="checkbox"/> Mental or nervous condition			
2 <input type="checkbox"/> Hearing problems	12 <input type="checkbox"/> Kidney disease	22 <input type="checkbox"/> Tumor or cancer			
3 <input type="checkbox"/> Frequent or severe headache	13 <input type="checkbox"/> Urinary problems	23 <input type="checkbox"/> Currently pregnant Due Date _____			
4 <input type="checkbox"/> Epilepsy or seizure	14 <input type="checkbox"/> Hepatitis or liver disease	24 <input type="checkbox"/> Other			
5 <input type="checkbox"/> Thyroid disease	15 <input type="checkbox"/> Hernia	25 Work Health History <i>Have you previously been exposed to any of the following agents? When / how long?</i> <input type="checkbox"/> Asbestos _____ <input type="checkbox"/> Hazardous Materials _____ <input type="checkbox"/> Ethylene Oxide _____ <input type="checkbox"/> Loud noise _____ <input type="checkbox"/> Infectious Disease _____			
6 <input type="checkbox"/> Heart disease	16 <input type="checkbox"/> Hand or wrist problems				
7 <input type="checkbox"/> High blood pressure	17 <input type="checkbox"/> Trick knee, shoulder, elbow				
8 <input type="checkbox"/> Asthma or lung disease	18 <input type="checkbox"/> Back pain or injury				
9 <input type="checkbox"/> Positive tuberculosis skin test	19 <input type="checkbox"/> Arthritis				
10 <input type="checkbox"/> Tuberculosis treatment	20 <input type="checkbox"/> Skin rash or dermatitis				
26 Have you seen a physician in the last year? Y N If yes, list month and reason.					
27 Comments for each item checked above:					
28 Hospitalizations/Surgeries (List procedures and dates):					
29 Have you had any of the following diseases? If yes give date of illness. Chickenpox _____ German Measles _____ Hepatitis B or C _____ Measles (Rubeola) _____ Mumps _____					
30 Immunization history and dates: Hepatitis B 1 st 2 nd 3 rd MMR 1 st 2 nd Varicella 1 st 2 nd Tetanus					
31. Tobacco Use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer					
STATEMENT OF UNDERSTANDING REGARDING PRE-PLACEMENT SCREEN The answers that I have given regarding my health status are true to the best of my knowledge. Falsification of any information in the questionnaire will result in termination. I understand that the information will be used to determine whether I am capable of performing the physical requirements of the position for which I am being considered. My signature below indicates my understanding of the above statements regarding my pre-placement health screen.					
Signature: _____ Date: _____					

NAME: _____ SOCIAL SECURITY NUMBER: _____

TO BE COMPLETED BY OCCUPATIONAL HEALTH STAFF

ASSESSMENT SCREENING TESTS (Check if applicable)

- Hepatitis B Surface Antibody (Quantitative)
- Hep B Antigen
- Rubella, Varicella, Rubeola, and Mumps Titers
- Urine Drug Screen
- Chest X-ray for previous converters
- PPD (LFA/RFA)
- Respirator Medical Clearance
- Respirator Fit Test

PHYSICAL ASSESSMENT

Blood Pressure:			
Visual Test: <input type="checkbox"/> With Correction <input type="checkbox"/> Without Correction			
Near	Both	Right	Left
Far	Both	Right	Left
Color	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormality Noted:	
Comments:			

PRE-PLACEMENT PHYSICAL ASSESSMENT COMPLETED BY:

Signature

Title

Date