Hartford HealthCare

MEDICAL & WORK HISTORY

Legal Name:	**Preferred Name:**
Date of Birth:	**Phone:**
Sex at Birth: ☐ Male ☐ Female ☐ Other	**Gender Identity:** ☐ Transgender Male/Female-to-Male ☐ Male ☐ Transgender Female/Male-to-Female ☐ Female ☐ Other
Preferred Pronouns: ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Theirs	

Is someone helping you fill out this form? ☐ Yes ☐ No

MEDICAL HISTORY

Have you ever had any of the following (if yes, please explain):	**No**	**Yes**	**Explain:**
Diabetes, Thyroid problems			
Epilepsy or Seizure Disorder/Dizziness/Fainting			
Back/Neck Problems (Disc, Sciatica)			
Bone/joint problems (swelling, injuries, arthritis, fractures)			
Shoulder or arm problems			
Bursitis or tendonitis, tingling or numbness in arm or leg			
Leg, knee or foot problems			
Muscle weakness			
Difficulty or pain walking, standing or sitting			
Spine or upper/lower extremity surgery			
Multiple Sclerosis			
Carpal Tunnel Syndrome			
Fibromyalgia			
Heart problems (heart attack, murmur, mitral valve prolapse, chest pain, palpitations)			
High Blood Pressure			
Skin Problems (eczema, psoriasis, acne, rashes, infections, hives etc.)			
Respiratory Problems (asthma, emphysema, chronic cough, chronic lung disease, shortness of breath, TB, coughing up blood)			
Hearing problems/Perforated ear drum/Difficulty hearing			
Vision problems/Cataracts/Glaucoma/Changes in vision			
Bleeding Problems/Anemia			
Kidney Disease			
Behavioral/Mental Health Concerns			
Frequent Headaches (Migraines)			
Alcohol/Drug problems/Stress/Depression			
Hepatitis/Jaundice/Cirrhosis			
Gastrointestinal Problems (GI, Stomach or digestive, Hernia)			
Hospital stay for a surgery or illness			
Have you been paid for Injuries or Illness by:			
Workers' Compensation Insurance			
Automobile Insurance after accident			
Disability/Social Security Insurance			
Allergies			

Office Notes: _____

_____

For Office Use: Department/Job Title: _____ Emp ID: _____
please fill in above colleague's department/job title and employee ID

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Name:	**Date of Birth:**

List of all medications currently taking: _____

Please answer the following questions:	**No**	**Yes**
Do you currently have a Primary Care Physician?		
If no, can we help you find one?		
Do you have a medical disorder or impairment that would interfere with the full performance of your duties?		
Have you left or been refused a job for health reasons?		
Have you received Workers' Compensation, been awarded a disability rating, or been assigned work restriction(s)?		
Do you have any medical conditions for which you need accommodations to perform your job?		
Do you have any hobbies, crafts, or "side jobs" which you do regularly?		

WORKPLACE HAZARDS

Have you worked for more than 6 months in a job where you may have come in contact with:					
	No	**Yes**		**No**	**Yes**
Blood and body fluids			Constant loud noise		
Radiation			Cytotoxic drugs used in Chemotherapy		
Lead			Chemicals such as cleaning solvents, paints, and acids		
Asbestos			Fumes, gases, or high levels of dust		

LATEX SCREENING

Latex is contained in many products found in the health care setting such as gloves, elastic bandages, ambu bags and adhesive tape. Examples of latex products in the home include balloons, household work gloves and condoms. Some people are at risk of latex allergy and should avoid latex containing products.

Please answer the following questions as accurately as possible:	**No**	**Yes**	**Explain:**
Do you have an allergy to any latex product?			
If yes, what type of allergic reaction (if known)?			
What latex products caused it?			
Do you have a personal/family history of eczema, asthma, or hay fever?			
Have you had any allergic reactions to bananas, avocados, kiwi fruit, chestnuts, other nuts, or any other food (e.g. tomatoes, papaya, passion fruit)?			
Have you had any of the following when exposed to latex (glove, balloons, Band Aids, condoms, rubber bands, rubber toys, BP cuffs, tourniquets, IV tubing, automobile tires, bottle nipples, diaphragms, etc.)?			
Dermatitis/Eczema			
Urticaria/"Hives"			
Asthma/Hay Fever			
Tight Chest			
Coughing/Sneezing			
Runny nose/Itchy or runny eyes			
Anaphylactic reaction			
Have you ever had a local reaction or swelling/itching following a medical/dental examination with latex gloves?			
Does your current occupation involve latex gloves?			
If yes, on average how many hours a day do you wear latex gloves?			
On average, how many times a do you change latex gloves?			

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TUBERCULOSIS SCREENING

Tuberculosis (TB) is due to bacteria that can cause a lung infection with cough, fever, and weight loss and can make other parts of the body sick as well. Some people who acquire the disease are very sick; others have few or no symptoms. It is transmitted through the air from person to person. Spread of the illness can be controlled by finding ill people early and by treating exposed people with antibiotics before they get sick.

Please answer the following questions as accurately as possible:	**No**	**Yes**	**Explain:**
Have you ever had or been told you had tuberculosis (TB)?			
Have you ever had a positive test (PPD skin test or blood test) for TB?			
If yes positive PPD skin test (red and swollen), when and induration?			Date: Induration: mm
If yes positive blood test (Quantiferon), when?			Date:
Have you ever had a chest x- ray?			
If yes, when and what were the results?			Date: ☐ Normal ☐ Abnormal
Have you ever had close contact with someone who has TB (such as a family member, coworker, etc.)?			
Did you grow up in a country other than the U.S.?			
If yes, in which country?			
Have you spent more than 30 consecutive days somewhere outside of the U.S.?			
Do you have any chronic illnesses for which you take medication or are followed by a doctor?			
If yes, what illness?			
Are you currently or have you recently been treated with cortisone or other steroids, anti-cancer, or immunosuppressive drugs?			
If yes, which method?			
Are you currently taking or have taken any of the following medications?			
Rifampin			
Isoniazid (INH)			
Pyrazinamide			
Ethambutol			
Rifapentine			
Have you had a MMR, oral polio, or yellow fever vaccine in the last six weeks?			
Do you have a cough that has lasted at least three weeks?			
Do you have any unexplained weight loss?			
Do you have a persistent low-grade fever?			
Do you have night sweats?			
Do you have a loss of appetite?			
Do you have swollen glands, usually in the neck?			
Have you been coughing up blood?			
Do you have shortness of breath?			
Do you have chest pain?			
Do you have any new unexplained tiredness?			

I certify that the information provided in this document is true and complete. Should Hartford HealthCare discover that I have falsified or omitted any material information, I understand that my offer of employment could be withdrawn.

Colleague Signature: _____ Date: _____

For Office Use: Department/Job Title: _____ Emp ID: _____

please fill in above colleague's department/job title and employee ID