Dartmouth-Hitchcock Medical Center
Occupational Medicine
One Medical Center Drive
Lebanon, NH 03756-0001
Phone (603) 653-3850
Fax (603) 650-0928
dhmc.org

Pre-Employment Screening Questionnaire
- 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, lead, 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.

Please print in all sections

Full Name:_____
First Middle Last

Today's Date: _____ Age: _____ Birth Date: _____ Social Security# _____

Primary Phone # _____ E-Mail address: _____

Address:_____City:_____ State:_____ Zip:_____

Department:_____ Job Title:_____

Anticipated Orientation Date: _____

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 relevant comment section. These forms are reviewed by Occupational Medicine medical staff. If it is determined that an in-person appointment is needed, please note that this will not be a diagnostic examination; it is solely to evaluate your ability and safety to perform required job tasks and to ensure the safety of those around you in the workplace.

WORK HISTORY

Please list past and current jobs you have performed over the past 10 years:

Employer	Job Title (or brief description of primary job tasks)	Dates of Employment

Name:_____

If not working, date last worked: ___ / ___ / _____ Reason for end of employment: _____

EXPOSURE HISTORY

Some assignments may involve exposure to noise, chemicals, biohazards, and various forms of radiation. We review your past exposure and tolerance to these agents prior to employment to ensure your safety. Considering this, carefully answer the following questions.

☐Yes ☐No Have you ever had a splash (to your open skin, eyes, nose, or mouth) or a needle stick (from a suture, syringe, blade, or other sharp device) that was contaminated with blood, body fluid, or other potentially infectious substance?

☐Yes ☐No If yes, did you seek medical care and complete post-exposure treatment if recommended?

☐Yes ☐No Have you ever worked with any of the following toxic or hazardous substances? If yes, please indicate specific exposures below:

☐Anesthetic agents	☐Anti-neoplastics	☐Arsenic	☐Asbestos
☐Benzene	☐Beryllium	☐Cadmium	☐Ethylene Oxide
☐Formaldehyde	☐Glycol Ethers	☐Lasers or masers	☐Lead
☐Mercury	☐Pesticides	☐Radioactivity	☐Silica
☐Solvents	☐Other (please list all): _____		

☐Yes ☐No Are you allergic to any chemicals with which you have worked?

☐Yes ☐No Have you ever had periodic physical examinations required by your employer because you worked with hazardous materials?

☐Yes ☐No Have you ever worked in a job that was noisy, made your ears ring, or made it hard for you to hear?

☐Yes ☐No Have you ever had a hearing test required by your employer because of exposure to noise?

☐Yes ☐No Have you ever left a job, changed your occupation, or been told by a medical provider to limit or restrict your work activities because of exposure to noise, chemicals, radiation, stress, physical demands, or other hazards in the work place? If so, please explain:

_____

_____

WORK CAPACITY

☐Yes ☐No Do you have any current work restrictions?

If yes, please describe and list the medical provider who recommended the restrictions on next page:

Current Work Restrictions	Name of Provider who Recommended Restrictions	Address or Name of Facility	Phone

Name:_____

"Second injury" funds have been established under various state Workers' Compensation programs to encourage employers to hire individuals with a history of prior work-related injuries. Inappropriate work assignments can worsen previous work-related injuries. Considering this, carefully answer the following questions.

☐Yes ☐No Have you ever lost time from work because of a work-related injury or illness?

If yes, please list the dates, type of injury, employer, and length of time you were out of work:

Date(s)	Type of Injury	Employer	Length of Time Out of Work

☐Yes ☐No Have you ever filed a Workers' Compensation claim because of a work-related injury or illness?

If yes, year of injury or illness:_____ Employer:_____

Type of treatment received: ☐PT/OT ☐Surgery ☐Other: _____

_____

☐Yes ☐No Do you have any Workers' Compensation claims that are still open or pending?

☐Yes ☐No Have you ever received a disability award or pension for a work-related injury or illness?

MEDICAL HISTORY

Some work assignments may be associated with chemical, biological, electrical, or physical hazards. For example, some jobs may require the ability to lift and carry heavy objects, to stand or walk on uneven surfaces, to climb on ladders or scaffolding, to perform prolonged bending of the neck and back, or to perform repetitive movements of the neck or extremities. Some work assignments could be extremely dangerous in the event of dizziness, loss of consciousness, or loss of balance.

Considering this, indicate if you have or have ever had any of the following conditions. Please describe in the space provided.

☐Heart disease:_____

☐High blood pressure: _____

☐Circulation or bleeding condition:_____

☐Stroke:_____

☐Asthma or breathing condition:_____

☐Hepatitis or liver condition:_____

☐Kidney condition:_____

☐Diabetes:_____

☐Low blood sugar:_____

☐Seizures or epilepsy:_____/_____

☐Nervous system condition:_____

☐History of fainting or losing consciousness:_____

☐Problems with balance:_____

☐Immune disorder or suppression:_____

☐Cancer: _____

☐Hernia:_____

☐Chronic infection: _____

☐Prosthesis:_____

☐Vision or hearing problem:_____

☐Color blindness:_____

☐History of anaphylaxis or throat swelling:_____

☐Gastrointestinal condition:_____

☐Sensitivity to chemicals or soaps:_____

☐Eczema, dermatitis, hives, or other skin condition: _____

☐Environmental, pet, seasonal, or product allergies:_____

☐Other:_____

Do you have any of the following orthopedic problems (including any muscle, joint, bone, or nerve condition) that affects your strength, grip, motion, or ability to sit, stand, walk, squat, kneel, bend, climb, lift, carry, or work on slippery or uneven surfaces). Please describe in the space provided:

☐Low back injury or problem:_____

☐Neck injury or problem:_____

☐Shoulder, elbow, or arm injury or problem:_____

☐Hand or wrist injury or problem:_____

☐Hip, knee, or leg injury or problem:_____

☐Foot or ankle injury or problem:_____

Do you have any pain, numbness, or loss of feeling in:

☐Yes ☐No Either hand?
☐Yes ☐No Has it limited the use of your hand or your ability to maintain a strong grip, hold objects firmly, or handle objects with your fingers?

☐Yes ☐No Either arm of shoulder?
☐Yes ☐No Has it reduced your strength or limit your normal range of motion?

☐Yes ☐No Either foot or leg?
☐Yes ☐No Has it caused weakness or limits to your range of motion or ability to stand, walk, squat, kneel or climb stairs?

☐Yes ☐No Your neck?
☐Yes ☐No Has it interfered with bending or turning your neck and holding it in any one position for any length of time?

☐Yes ☐No Your back?
☐Yes ☐No Has it reduced strength or interfered with your ability to bend your back often; to lift, carry, push or pull heavy objects; or to work in a stooped or squatting position?

Do you have a Primary Care Provider? ☐Yes ☐No

If yes, please provide name of provider and practice location: _____

Females Only

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

SURGICAL HISTORY

Please list below ALL types and dates of surgeries or operations that you have had.

Surgical Procedures	Date of Surgery

☐Yes ☐No **Have you been advised to have a surgical operation that has not been performed?**

MEDICATIONS

List below ALL medications that you are currently taking including prescription, over-the-counter, non-prescription, pain medication, narcotics, herbs, supplements, and vitamins.

Name of Medication	Reason for Taking

☐Yes ☐No **Are you using any narcotic pain medication or patch such as, but not limited to, Percocet, Vicodin, oxycodone, methadone, fentanyl patch, etc.) or Suboxone?**

☐Yes ☐No **Are you on a narcotic or opiate contract? If yes, with whom (please note on next page):**

Name:_____

Name of Narcotic Pain Medication/Patch	Address or Name of Facility	Phone	Date(s) of Treatment

ALLERGIES

☐ **Check here if you have no known medication allergies.**

Please list below ALL allergies or sensitivities you have to medications and what happened when you took it.

Medication	Type of Reaction

☐Yes ☐No Do you have any food allergies?

If yes, are you allergic to or do you have reactions to any of the following foods, such as mouth tingling, lip swelling, itchy throat, runny nose, wheezing, itching, or nausea?

☐Avocado ☐Banana ☐Chestnut
☐Kiwi ☐Tree nuts ☐Peanuts
☐Passion Fruit ☐Peach ☐Tomato
☐Raw Potato ☐Papaya ☐Eggs
☐Other Foods (please list):_____

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 (Social and Wellness History).

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

Name of Provider	Address or Name of Facility	Phone	Date(s) of Testing

☐Yes ☐No Have you had a reaction to any of the following products within one hour of exposure such as itching, redness, swelling, hives, runny nose, congestion, wheezing, or chest tightness)?

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

☐Yes ☐No Have you had any problems or skin reactions with glove use?
If yes, please describe:_____

SOCIAL AND WELLNESS HISTORY

☐Yes ☐No Do you have a sleep disorder or problems sleeping that interferes with your alertness at work?

☐Yes ☐No Have you ever been convicted for illegal possession, use, or distribution of drugs or been convicted of driving under the influence of drugs or alcohol (DUI)?

☐Yes ☐No Are you currently or have you ever used tobacco or nicotine products?
If currently using, how many packs/pouches/tins per day:___ Number of years:_____

☐Yes ☐No Are you currently or have you ever received counseling or have you even been treated for substance use or abuse (including alcohol or drugs)?

If yes, please describe and list your treating provider:

Treating Provider	Address or Name of Facility	Phone	Date(s) of Treatment

Regarding legal, illegal and prescription drug use:

☐Yes ☐No Have you ever felt that you ought to cut down on your drinking or drug use?

☐Yes ☐No Have people annoyed you by criticizing your drinking or drug use?

☐Yes ☐No Have you ever felt bad or guilty about your drinking or drug use?

☐Yes ☐No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

☐Yes ☐No Do you currently or have you ever had a psychiatric disorder such as, but not limited to, depression, anxiety, panic, eating disorder, claustrophobia, obsessive compulsive disorder, bipolar disorder?

If yes, please describe and list your treating provider (on next page):

Name of Narcotic Pain Medication/Patch	Address or name of Facility	Phone	Dates of Treatment

IMMUNIZATION HISTORY

DHMC Infection Control Policy requires all staff to provide proof of immunity or immunizations for measles (rubeola), German measles (rubella), mumps, chickenpox (varicella), pertussis (Tdap), and seasonal influenza. Please provide documentation of your entire immunization history including vaccinations and serological testing. You can contact your primary care provider, pediatrician, college or high school for these records. By providing immunization documentation you can help us conserve resources. If immunization records are not provided, necessary vaccines will be administered through Occupational Medicine.

In addition, all D-H staff are required to participate in a Tuberculosis Surveillance Program, which includes a baseline TB PPD skin test, a Quantiferon or T-spot blood test, or completion of annual symptom questionnaire if you have a history of previous positive TB test. **Please provide any documentation of previous TB testing, including a copy of the chest x-ray report if you have a history of a positive TB test.**

When was your last TB test? _____

☐Yes ☐No Have you previously had a positive PPD (skin test), Quantiferon, or T Spot test?
If yes*, did you receive medication(s) and if so, what medication and for how long?
**if yes, please provide a copy of your chest x-ray report*

Medication	Type of Reaction

FEDERALLY-MANDATED OSHA RESPIRATOR CLEARANCE

Please read and complete all of the following questions carefully, even though some questions are the same as some you have already answered above. THIS IS A FEDERALLY REQUIRED QUESTIONNAIRE.

Respirators that may be used by DH staff for respiratory protection at DHMC include the N95 tuberculosis respirators and the Powered Air Purifying Respirators (PAPR).

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

Name:_____

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 breathe 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:_____

Any other medical or mental health conditions that you feel could interfere with your ability to do this job?

_____

_____

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:_____

_____

_____

Name:_____

8. Have you ever worn a respirator? ☐ Yes ☐ No (If you've never used a respirator, please go to question 10.)

9. Have you ever had any of the following problems while using a respirator?

☐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, please explain:			

_____

_____

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

Comments:_____

_____

****************************END OF OSHA QUESTIONNAIRE************************

I have answered the questions to the best of my knowledge. I understand that this questionnaire is to assist the Occupational Medicine staff in ensuring I meet D-H infection control requirements and determine my ability to safely perform the functions of this position for which I have applied at Dartmouth Hitchcock.

☐Yes ☐No **I believe I can perform those functions in a safe manner.**

If NO, please explain: _____

☐**Yes** ☐**No** **I understand that deliberate omission or falsification of information on this form may be reason for disciplinary actions up to and including termination.**

☐**Yes** ☐**No** **I permit the section of Occupational Medicine to have access to my complete Dartmouth Hitchcock medical record for the purposes of immunization review and update. I understand that my evaluation will not be affected if I do not grant this permission.**

_____ _____

Applicant Signature Today's Date

Dartmouth Hitchcock Medical Center-Occupational Medicine
One Medical Center Drive
Lebanon, NH 03756
Phone: 603-653-3850
Fax: 603-650-0928
e-mail: occmedadmin@hitchcock.org

Name:_____

WELCOME TO DARTMOUTH-HITCHCOCK! Dartmouth-Hitchcock's vision is to achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for our nation. Achieving the healthiest population possible starts here, at Dartmouth-Hitchcock, with our own workforce. We are here to support you with services in Employee Assistance Program (EAP), Health Improvement and Coaching, Primary Care, Occupational Medicine and Work Ability.

Live Well/Work Well is a health and well-being program that offers employees and their families the resources to be able to enjoy a healthier lifestyle and do what they want to do at home and at work. Information regarding services available to you and your partner/family will be provided to you upon your request below. To ensure proper delivery of this information, please complete the form below.

First Name:	**Middle Initial:**	**Last Name:**

Date of Birth:	**Start Date:**

Do you and your family have a PCP?	
☐ Yes If so, who?:	☐ No Would you like us to assist in finding your family a PCP? ☐ Yes ☐ No

Partner/Spouse Name	**Dependent(s) Name(s):**

Do you have any health needs that you need assistance with?	
☐ Yes ☐ No	If yes, what?

Who is the preferred contact?	**What is the best time to reach you/your spouse?**	**What is the preferred method of contact?**
☐ Me ☐ Spouse/Partner	☐ AM ☐ PM	☐ Mail ☐ eMail ☐ Phone

Mailing Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Email Address:**	

Please send me more information on:			
Employee Assistance Program ☐	Health Improvement & Coaching ☐	LWWW Primary Care ☐	Occupational Medicine ☐

By signing below, I permit the section of Occupational Medicine to share this 1-page form with Live Well/Work Well for the purposes of receiving future correspondence with resource options and I understand that my evaluation will not be affected if I do not grant this permission.

_____ _____

Applicant Signature Today's Date

Name:_____

D-H EMPLOYEE/PROSPECTIVE EMPLOYEE AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

All sections of this form must be filled out completely or it will not be accepted.

I hereby authorize Dartmouth-Hitchcock to use/disclose my individually identifiable health information (which may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, STD's, or genetic testing records, if applicable). I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, such as insurance company or health care provider the disclosed information may no longer be protected by federal and state privacy regulations.

Patient Name: _____ DOB: _____

Address: _____ Phone Number: _____

Purpose of the use and/or disclosure:

□ To permit Dartmouth-Hitchcock's Occupational and Environmental Medicine section to have access to my complete Dartmouth-Hitchcock electronic medical record for purposes of providing care and treatment that I receive in Occupational and Environmental Medicine, and to record such care and treatment in that medical record.

□ To permit Dartmouth-Hitchcock's Occupational and Environmental Medicine section to update my immunization record in my Dartmouth-Hitchcock electronic medical record each time I receive any immunization from Occupational and Environmental Medicine.

• I understand that this authorization will expire at the time my employment terminates.
• I further understand that I may revoke this authorization at any time by notifying Dartmouth-Hitchcock in writing at One Medical Center Drive, Lebanon, NH 03756, except to the extent it has already been relied upon.

_____ _____ _____
Signature of Patient or Personal Representative Phone Number Date

_____ _____
Printed Name of Personal Representative Legal Authority of Personal Representative

Name:_____

********** **To be completed by OM Staff**********

Summary of findings and additional comments: _____

_____

_____

_____

Recommendations (or see Fitness for Duty Form and OHM note):

☐ Able to work without or with restrictions or accommodations

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

Date letter sent: _____ Provider:_____

☐ Medical hold pending required Occupational Medicine provider visit and documented in the OHM record

Nursing documentation of immunizations (or see OHM record):

Titers Drawn	**TB**	**Vaccines administered**
☐ Hepatitis B	☐ PPD planted _____	☐ Tdap
☐ Rubella	☐ CXR (PA only)	☐ MMR
☐ Rubeola	☐ Positive PPD questionnaire completed	☐ Varicella
☐ Varicella	☐ Quantiferon	☐ Hepatitis B
☐ Mumps	☐ T-Spot	☐ Influenza
☐ Other		☐ Other

Date of General Orientation: _____

Information Sheet sent to LWWW PC? ☐ **Yes** ☐ **NO**

_____ _____

Occupational Medicine Nurse Reviewer Date

LH/JLL 9/15