Grandell Rehabilitation & Nursing Center

645 West Broadway, Long Beach, New York 11561-2902

EMPLOYEE MEDICAL HISTORY

(please print clearly)

Employee's Name: _____ Date: _____

Department: _____ Date of Birth: _____

Please answer whether you have (or had) any of the following and give date of onset:

Typhoid Fever	yes _____	no _____	date of onset _____
Tuberculosis	yes _____	no _____	date of onset _____
Diabetes	yes _____	no _____	date of onset _____
Mental or Emotional Illness	yes _____	no _____	date of onset _____
Epilepsy	yes _____	no _____	date of onset _____
Back Problems	yes _____	no _____	date of onset _____
Cardiac Problems	yes _____	no _____	date of onset _____
Hypertension	yes _____	no _____	date of onset _____
Infectious Mononucleosis	yes _____	no _____	date of onset _____
Hepatitis A or B	yes _____	no _____	date of onset _____
Blood/lymph disease			
Leukemia or Hodgkins	yes _____	no _____	date of onset _____
Other _____	yes _____	no _____	date of onset _____

If you have answered yes to any of the above, please explain:_____

_____

Do you take corticosteroids (prednisone, cortisone)? NO_____ YES_____ If yes, please explain _____

_____

_____

Are you taking any immunosuppressive drugs (azathioprine, cyclosporine, muromonab)? NO_____ YES_____

If yes, please explain_____

_____

List all other currently prescribed medications:

_____ _____

_____ _____

Are you habituated or addicted to depressants, stimulants, narcotics, alcohol or other substances?

Yes_____ No_____ If yes, please explain:_____

Please list all allergies, if any:_____

If you have been hospitalized in the past 5 years, please explain and give details (include year, diagnosis, surgery and treatment):_____

_____

If you have had a major illness in the past, please explain and give details:_____

_____

_____

Tuberculosis Screening

1. Do you have any of the following symptoms:

CIRCLE BELOW	NO	YES
Fever	____	____
Tiredness	____	____
Weakness	____	____
Night Sweats	____	____
Loss of Appetite	____	____
Unexplained Weight Loss	____	____
Swelling in Neck, Armpits, Groin	____	____
Cough with Sputum	____	____
Blood Tinged Sputum	____	____

IF YES, PLEASE EXPLAIN

_____

_____

_____

_____

2. Do you have a history of induration, sensitivity, and/or allergy to PPD testing? NO_____ YES_____
Date of Last PPD_____ RESULTS: Negative_____ Positive_____

3. Have you ever received a course of prophylactic treatment for TB?

NO_____ YES_____ If yes, complete the following:
Start Date_____ End Date_____
Medications_____

4. Have you received the BCG vaccine within the past 10 years? NO_____ YES_____
If yes, date of BCG Vaccine_____

* * * * * *

PHYSICAL EXAMINATION - TO BE COMPLETED BY EXAMINING PHYSICIAN ONLY

	NORMAL	ABNORMAL	EXPLAIN IF ABNORMAL
Overall Appearance:	_____	_____	_____
Skin:	_____	_____	_____
Eyes:	_____	_____	_____
Ears, nose, throat:	_____	_____	_____
Neck:	_____	_____	_____
Breasts:	_____	_____	_____
Thorax:	_____	_____	_____
Lungs:	_____	_____	_____
Heart (BP):	_____	_____	_____
Abdomen:	_____	_____	_____
Genitalia:	_____	_____	_____
Pelvic:	_____	_____	_____
Rectal:	_____	_____	_____
Extremities:	_____	_____	_____
Neurological:	_____	_____	_____

P.P.D. (Mantoux) mandatory Date:_____ Results:_____

TB Disposition* _____

_____

_____

IMPORTANT - PLEASE NOTE ALL CONTINUED EMPLOYMENT MEDICAL REQUIREMENTS:

**Physician must complete TB MEDICAL AND EXAMINATION FORM on back of this form if employee reports a history of induration, sensitivity and/ or allergy to PPD testing or if employee has a PPD skin reaction. Attach copies of all test results (i.e.: a current chest X-ray report including results and date of chest X-ray).*

_____ _____

Signature of Examining Physician Date of Exam

PLEASE PRINT CLEARLY AND STAMP

Physician Name _____

Address _____

_____

Telephone No. _____

STAMP BELOW:

If there is a (history of) sensitivity to P.P.D./Mantoux or Tine test, your examining physician must complete the TB MEDICAL AND EXAMINATION FORM and attach all test results (i.e.: a current chest X-ray report including results and date of chest X-ray).

I acknowledge having been informed that the facility provides for the Hepatitis B vaccination to employees at risk and that a request for the vaccination must be submitted in writing to the Assistant Director of Nursing Services -Infection Control Coordinator.

I acknowledge that I have provided a complete and accurate medical history record.

_____ _____

Signature of Employee Date

I have reviewed and examined the above information.

_____ _____

Signature of Examining Physician Date

TB SCREENING FOR EMPLOYEES
MEDICAL EVALUATION AND TREATMENT FORM

TO BE COMPLETED BY EXAMINING PHYSICIAN

In accordance with Federal Regulations, Vol. 58, No. 195, Section J, and facility policy regarding TB Screening of Health Care Workers, a follow-up evaluation to rule-out TB, and if indicated, the need to provide adequate appropriate therapy is required.

CHECK ONE:

_____ Employee reports a history of induration, sensitivity, and/or allergy to PPD testing.

_____ Employee has a PPD skin reaction of _____ mm.

PROCEDURE/S USED TO RULE OUT TB*:

_____ Chest X Ray _____ Physical Exam _____ 3 Consecutive Sputum for AFB

_____ Other _____

MEDICAL OPINION:

____ No active TB disease and is medically cleared to work.

____ Prophylactic therapy recommended. Reason (i.e.: latent TB; known exposure; positive PPD; etc.):

_____

Medications Ordered:_____ Dosage:_____

Frequency:_____ Duration:_____ Active TB:____ Medications Ordered:_____

Dosage:_____ Frequency:_____ Duration:_____ Other _____

WERE SIGNS AND SYMPTOMS OF TB AND IMPORTANCE OF REPORTING THE ONSET OF ANY SIGN OR SYMPTOM DISCUSSED WITH EMPLOYEE?

YES_____ NO_____

COMMENTS: _____

_____

_____

_____

IMPORTANT REMINDER - PLEASE ATTACH COPIES OF ALL TEST RESULTS INCLUDING MEASLES, MUMPS, RUBELLA, AND TITERS

_____ _____

SIGNATURE OF PHYSICIAN DATE