CONFIDENTIAL
HEALTH HISTORY EVALUATION

Aspirus Employee Health Services
Aspirus Wausau Hospital 333 Pine Ridge Blvd Ste. F-7 Wausau WI 54401
Phone: 715-847-2785 Fax: 715-847-2786

Date of Evaluation: _____________

EMPLOYEE TO COMPLETE

Name: (Last) (First) (Middle)	Employee # Date of Birth	Facility/Department:
Street:	Phone:	Job Title:
City:	Alternate Phone:	Expected Date of Employment:
State: Zip code:	Emergency Contact Person: Emergency Number:	Primary Care Provider: Location:

1. MEDICATIONS: Please list the name, dose, and frequency: ☐ I currently am not taking any medications.

2. ALLERGIES: Please list any allergies and symptoms:

3. MEDICAL HISTORY

Please circle EACH INDIVIDUAL health problem(s) that you currently have or have had in the past (not circled indicates never experienced).

a. Lung problems; Spitting up blood; Chronic cough; Asthma; Shortness of breath; or other problems of the lungs or respiratory system
b. Heart problems; Heart attack; Heart surgery, Chest pain; Palpitations; Cardiac pacemaker; High blood pressure
c. Vascular problems; Swelling of the legs or ankles; Varicose veins; Phlebitis
d. Neurological problems; Stroke or paralysis; Dizziness; Fainting spells; Seizures or epilepsy; Severe headaches; or any other disorder of the brain or nervous system
e. Gastrointestinal disorders; Stomach ulcers; Recurrent or persistent diarrhea; or other disorders of the intestines or rectum; Hepatitis; Liver trouble
f. Immune system problems; Thyroid problems; Diabetes; Blood disease; Anemia
g. Musculoskeletal problems; Neck/shoulder/elbow/wrist/hand injury, problems or pain; Numbness or tingling in the arms or hands; Back injury, sprain, strain, pain or other condition of the spine; Knee /ankle/foot injury, problems or pain; Numbness or tingling in legs or feet; Tendonitis: Carpal tunnel syndrome; History of fractures; Bone or joint problems; Arthritis; Gout
h. Kidney/Bladder problems; Nephritis; or other diseases of the kidneys or bladder
i. Skin problems or skin conditions; Chronic rash; Hives; Herpes; or other problems with the skin
j. Psychological or emotional problems; Anxiety; Depression
k. Hernia or Rupture
l. Cancer or Tumor

Additional health problem(s) not listed:
____

4. SURGERY(S) OR HOSPITALIZATIONS (please list with dates):

____
____

5. RESTRICTIONS/NEED FOR ACCOMMODATIONS

Do you have any physical or mental limitations which will require accommodations in order to allow you to perform the job for which you are being hired? Yes ☐ No ☐
Do you currently have any temporary or permanent work restriction related to a medical condition, surgery or injury? Yes ☐ No ☐
Have you ever had a work-related injury or illness? Yes↑ No ☐
Do you have any permanent work restrictions from a workers' compensation claim or a non-work related injury? Yes ☐ No☐
If any yes answers, **please provide details** of any restrictions or need for accommodations:
____

HEALTH CARE PR0FESSIONAL COMMENTS SECTIONS 1, 2, 3, 4 and 5:

____
____
____

EMPLOYEE NAME: ______________________________________

6. Do you currently, or have you ever been diagnosed with a communicable or infectious disease? Yes ☐ No ☐ **If yes, explain:**

7. Hepatitis B Vaccinations:
☐I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. ☐ I have completed the Hepatitis immunization series. Date completed: _____________________________ Location of Record: ______________________________________ ☐ I would like to receive the Hepatitis B vaccination; series of 3 injections given at 1, 2, and 6 month intervals ☐ **I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B virus.** (If under 18 years, parental consent required at the time of vaccination).

8. LATEX ALLERGY SCREENING
Have you ever had a rash after using latex products? Yes ☐ No☐
Have you ever had a contact reaction (lips or tongue swelling) when blowing up a balloon? Yes☐ No☐
Have you experienced a respiratory reaction such as asthma or runny nose that you believe is caused by latex? Yes ☐ No☐
Have you ever experienced or been told you had an anaphylactic reaction caused by latex? Yes ☐ No☐
Have you been tested for latex allergy? Yes ☐ No ☐ Which test: ☐RAST Test (Blood test) ☐Skin Prick Test Results: ☐Positive ☐ Negative

9. WELLNESS	
Tobacco use Yes ☐ No ☐ If yes: Pack/day __________ Former Date quit: ___________ Number of years smoking: ________ Do you exercise regularly: Yes ☐ No ☐ Would you say your present health is: Excellent ☐Good☐ Fair ☐ Poor ☐	History of alcohol/drug problems Yes ☐ No ☐ Have you ever been treated for substance abuse related to alcohol or illicit drugs? Yes ☐ No ☐ Alcohol use: Yes ☐ No ☐ If yes, how many drinks per day/week:______

10. VISION AND HEARING	
History of eye problems Yes ☐ No ☐ Eye(s) injury: Right ☐ Left ☐ Eye(s) surgery: Right ☐ Left☐ Wear: contacts/glasses/both Date of last vision exam: ___________ ☐ N/A	History of hearing loss/ear troubles Yes ☐ No ☐ Ear(s) surgery: Right ☐ Left☐ Do you wear hearing aids: Right ☐ Left ☐ Date of last hearing evaluation: __________ ☐ N/A

I have read the above and declare that I have not had any injury, illness, or ailment other than specifically noted in the information provided. I understand this will become a part of my Employee Health record. Falsification or misrepresentation may result in release from employment.

Employee Signature:____ Date:____________

HEALTH CARE PROFESSIONAL TO COMPLETE ***Biometrics Drawn: YES NO*** ***Titers Drawn: YES NO***

Heart rate: ________ Regular ☐ Irregular☐	Monovision: Yes ☐ No Type of correction: Reading Distance☐
Blood Pressure: Right ☐ Left ☐	Ishihara Color vision: PASS ☐ FAIL ☐ Examination completed with vision correction: Yes ☐ No ☐
Temperature: Respirations:	Near vision: Left 20/ Right 20/ Both 20/
Height: __________ Weight: __________ BMI: __________	Snellen vision: Left 20/ Right 20/ Both 20/

HEALTH CARE PROFESSIONAL COMMENTS SECTIONS 6, 7, 8, 9 and 10:

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______________________ _____________________________________ __________ ________

Health Care Professional Signature **Address** **Phone** **Date**

Revised: 8/28/2015