KAISER PERMANENTE

Kaiser on the Job

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Preplacement Health History Questionnaire and Assessment

Name_____Male ☐ Female ☐ Date of Birth_____

Home Address_____

Home Phone_____Cell_____SocSec#_____

Your EMAIL _____

Company you are applying for_____Department_____

Position you are applying for_____

Introduction:

The information you provide in this questionnaire is extremely important. It will be used by a physician or health care professional to evaluate your ability to perform the essential functions of the job safely without endangering yourself or others. Please fill out the questionnaire completely and accurately so that an employment decision can be made which will benefit both you and you and your employer.

All statements are subject to verification; and deliberate inaccuracies or incomplete statements may bar or remove you from employment.

Please answer all questions completely. Do not leave any answers blank; use either "NA" (not applicable) or "Don't Know".

1. List your last 3 hospitalizations (**excluding routine childbirth**):

Date **Age** **Condition** **Name of Hospital, City & State**

_____
_____
_____
_____
_____
_____

2. List any other operations or surgeries not included above:

Date **Age** **Condition** **Name of Hospital, City & State**

_____
_____
_____
_____
_____
_____
_____

3. **Date of Immunizations**: Tetanus _____Hepatitis B series complete_____Rabies_____

4. List all Medications (prescription and non-prescription) that you are currently taking (including vitamins, aspirin, antihistamines, cold medication, reducing aids, recreational drugs, etc):

_____
_____
_____
_____
_____

5. List all meds (prescription and non-prescription) not listed above that you have taken in the past two months:

_____
_____
_____
_____

6. **Exercise**

What do you do for exercise?_____

#days/week_____#minutes/day_____

7. **Do you have, or have you ever had:**

☐No ☐Yes ☐? Vision problems (color/night blindness, blurred vision, glaucoma, cataract, other)

☐No ☐Yes ☐? Skin condition (recurrent eczema, irritated skin, open lesions)

☐No ☐Yes ☐? Hearing problems

☐No ☐Yes ☐? Dizziness/fainting/loss of consciousness

☐No ☐Yes ☐? Depression or emotional disorder

☐No ☐Yes ☐? Prior drug/alcohol treatment

☐No ☐Yes ☐? Asthma/shortness of breath

☐No ☐Yes ☐? Tuberculosis

☐No ☐Yes ☐? Chest pain or heart problems

☐No ☐Yes ☐? Heart murmur/irregular heart beat

☐No ☐Yes ☐? Diabetes

☐No ☐Yes ☐? Hepatitis

☐No ☐Yes ☐? Anemia

☐No ☐Yes ☐? Cancer or leukemia

☐No ☐Yes ☐? Hernia

☐No ☐Yes ☐? Carpal tunnel syndrome

☐No ☐Yes ☐? Sleep Apnea

☐No ☐Yes ☐? Headaches

☐No ☐Yes ☐? Convulsions/seizures/epilepsy

☐No ☐Yes ☐? Psychological problems/stress

☐No ☐Yes ☐? Chronic Fatigue/Gulf War Syndrome

☐No ☐Yes ☐? Chronic cough

☐No ☐Yes ☐? Pneumothorax

☐No ☐Yes ☐? Swollen ankles or varicose veins

☐No ☐Yes ☐? High blood pressure

☐No ☐Yes ☐? Thyroid problems

☐No ☐Yes ☐? Ulcer/irritable bowel/Crohn's Disease

☐No ☐Yes ☐? Bleeding tendency

☐No ☐Yes ☐? Bad reaction to cold, heat, heights or closed spaces

☐No ☐Yes ☐? Numbness of extremities

☐No ☐Yes ☐? Fractures (broken bones)

Chronic or recurring pain or limited motion associated with:

☐Neck ☐Wrist ☐Back ☐Ankle ☐Shoulder

☐Hand ☐Hip ☐Foot ☐Elbow ☐Knee

Please Check One – "No" "Yes" "?"

8.. Do you drink alcoholic beverages at least once per week? ..... ☐No ☐Yes ☐?

9. Do you smoke cigarettes at least once per week? ..... ☐No ☐Yes ☐?

10. Are you currently taking any drugs or illegal substances not authorized by your physician or health care professional for medical purposes? ..... ☐No ☐Yes ☐?

11. Have you ever had a reaction, allergy, and/or sensitivity to any drugs (such as codeine, penicillin, or sulfa), latex, foods, plants, or chemicals? ..... ☐No ☐Yes ☐?

12. Are you currently under medical care for any emotional or physical illnesses? ..... ☐No ☐Yes ☐?

13. Have you been advised to have any operations which have not yet been done? ..... ☐No ☐Yes ☐?

14. Have you ever had an injury at work? ..... ☐No ☐Yes ☐?

When?:_____

15. Do you currently have a workers' compensation or disability claim pending? ..... ☐No ☐Yes ☐?

16. Are you currently receiving any medical disability payments (SDI, VA, LTD, SSI, etc.)? ..... ☐No ☐Yes ☐?

17. Have you ever changed jobs or work assignments because of any health problems or injuries? ..... ☐No ☐Yes ☐?

18. Have you ever had a physician or health care professional give you activity restrictions? ..... ☐No ☐Yes ☐?

19. Have you missed more than one week of work, due to health reasons, in the last year? ..... ☐No ☐Yes ☐?

20. Have you ever seen a physician or health care professional because of any back/neck/joint problems? ☐No ☐Yes ☐?

21. Have you ever been off work because of any back/neck/joint problems? ☐No ☐Yes ☐?

22. Have you had menstrual problems that kept you off work? ☐No ☐Yes ☐?

23. Have you ever been absent from work due to job stress? ☐No ☐Yes ☐?

24. Do you take medications at work or before work which you believe could affect your physical or mental function or performance? ☐No ☐Yes ☐?

25. Have you ever been unable to hold a job or refused employment because of any physical, mental or other health related reason? ☐No ☐Yes ☐?

26. Have you ever been rejected or discharged from a military position because of any physical, mental or other health related reason? ☐No ☐Yes ☐?

27. Within the past year, have you had repeated feelings of numbness, tingling, or "pins and needles" sensations in one or both hands? ☐No ☐Yes ☐?

28. Within the past year, have you had repeated feelings of soreness or pain in either forearm or elbow? ☐No ☐Yes ☐?

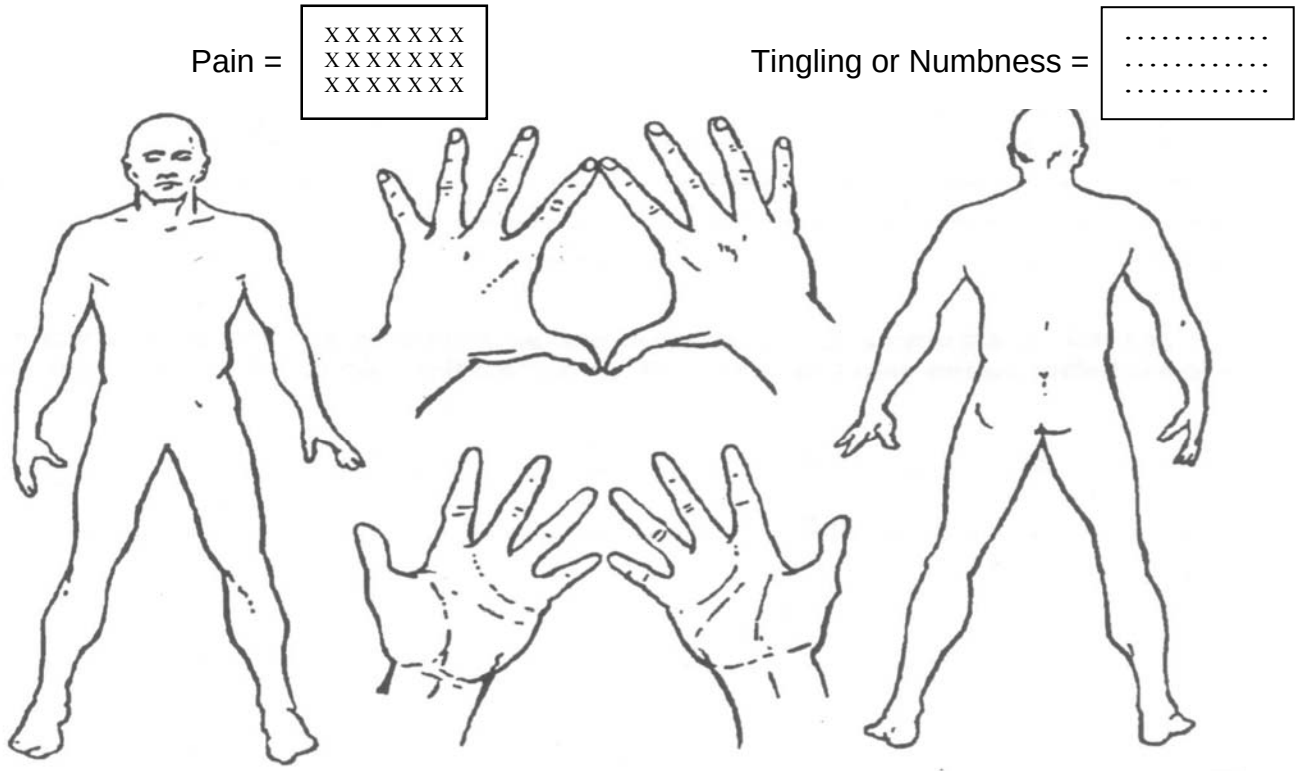
29. Have any of the above symptoms (numbness, tingling, soreness or pain) caused you to be awakened while sleeping? ☐No ☐Yes ☐?

30. Does discomfort in your wrist, arm or shoulder interfere with your daily activities (eating, writing, sports, etc.)? ☐No ☐Yes ☐?

31. Have you ever received medical treatment for this pain and/or discomfort? ☐No ☐Yes ☐?

32. Does your present job require arm, hand, or finger actions to be repeated many times each hour or work shift? ☐No ☐Yes ☐?

33. Please mark on the diagrams below where, in the past year, you have had:



34. List jobs you have had over the past 10 years beginning with your current or most recent job?

Employed	**Employer**	**Job Duties**

35. Have you ever worked with any of the following? (check all that apply):

- ☐ Asbestos
- ☐ Lead
- ☐ Radiation
- ☐ Dust
- ☐ Noise
- ☐ Silica Powder
- ☐ Latex
- ☐ Pesticides
- ☐ Solvents
- ☐ Lasers
- ☐ Paints and glues
- ☐ Other chemicals
- ☐ Substances which irritated your skin or eyes
- ☐ Substances which caused you breathing difficulties

36. Relative to this job, is there any health-related conditions for which you require accommodation *(i.e.,* job modification or structural changes in the work area)? If so, please list:

I hereby certify that all of my statements and answers are true and complete, and I understand that any misstatement of material fact may subject me to disqualification or dismissal and may cause forfeiture of all rights to employment.

Signature in full: _____ Date: _____

Reviewer: _____ Date: _____