

Montefiore Medical Center
Occupational Health Service (OHS)
Medical Examination form

NAME: (Last) _____ (First) _____
 ADDRESS: _____ DATE OF BIRTH: _____
 _____ MRN #: _____
 (City), (State) (Zip)
 HOME # _____ CELL # _____
 DEPARTMENT: _____ SUPERVISOR: _____
 Position: _____ STARTING DATE: _____

HAVE YOU EVER WORKED AT: MONTEFIORE MEDICAL CENTER AECOM WHEN?: _____

	<u>YES</u>	<u>NO</u>
1. Do you have any allergies? (check) <input type="checkbox"/> medication <input type="checkbox"/> seasonal <input type="checkbox"/> Latex <input type="checkbox"/> Other Please list allergies and reactions: _____		
2. Do you have any condition that will require special working arrangements?	_____	_____
3. Have you consulted a physician for any reason during the past three years other than routine physicals?	_____	_____
4. Have you ever been treated by a psychiatrist or psychologist?	_____	_____
5. Have you been hospitalized for any reason other than childbirth during the past 10 years?	_____	_____
6. Have you ever been disqualified from any job for any medical reasons or classified 4F or unfit for duty by any branch of the armed forces?	_____	_____
7. Have you had any accidents or injuries?	_____	_____
8. Have you ever applied for workers' compensation insurance?	_____	_____
9. Have you missed more than eight days per year from school or work because of an illness during the past three years?	_____	_____
10. Have you had any operations? a. Have you ever been advised to have an operation that you did not have?	_____ _____	_____ _____
11. Have you ever been refused life insurance or been asked to pay an extra premium?	_____	_____

NAME: (Last) _____ (First) _____

	<u>YES</u>	<u>NO</u>
12. Have you ever had high blood pressure (hypertension)? Any family member?	_____	_____
13. Have you ever been prescribed medication or a special diet for your blood pressure?	_____	_____
14. Do you or any family member have diabetes?	_____	_____
15. Do you have sickle cell disease or trait? Does anyone in your family?	_____	_____
16. Have you been out of the continental United States in the past two years?	_____	_____
17. Do you have eczema or any skin disease or does anyone in your household have eczema?	_____	_____
18. Do you smoke? If Yes, how much? _____	_____	_____
19. Do you take any drugs or medications?	_____	_____
20. Do you drink more than three alcoholic beverages daily?	_____	_____
21. Do you have a private physician or do you attend a medical clinic? If so, please indicate name and address: _____		

<u>Have you had?</u>	<u>YES</u>	<u>NO</u>	<u>Do you currently have?</u>	<u>YES</u>	<u>NO</u>
rubella	_____	_____	asthma	_____	_____
measles	_____	_____	anemia	_____	_____
mumps	_____	_____	arthritis	_____	_____
tuberculosis	_____	_____	hernia	_____	_____
chicken pox/varicella	_____	_____	back pain/problem	_____	_____
rheumatic fever	_____	_____	seizure disorders	_____	_____
heart disease	_____	_____	vision problems	_____	_____
back pain/problem	_____	_____	hearing problems	_____	_____
hepatitis	_____	_____	immune deficiency	_____	_____
seizure disorders	_____	_____	chronic cough	_____	_____
			chronic headaches/migraines	_____	_____
			Any other medical problem?	_____	_____

NAME: (Last) _____ (First) _____

Women Only:

Date of last visit to gynecologist: _____ Are you currently pregnant? Yes No

Date of last mammogram: _____ Do you perform self breast exam? Yes No

A safe and effective vaccine is available cost free to hospital employee who are at risk of contracting hepatitis B. All employees who have contact with blood or body fluids are at risk. Please answer these additional questions to help us in determining your potential exposure to the hepatitis B virus.

1. Will you be handling blood or body fluids in your position at Montefiore Medical Center?
 Yes No

2. Have you received the hepatitis B vaccine? Yes No Do not know or remember.

If yes, when and where? _____

If no, are you interested in receiving the vaccine? Yes No

All answers and statement provided by me on this examination form are complete and true. I understand and agree that my employment depends on full disclosure of all medical information and that any false or misleading statements can lead to immediate dismissal.

Signature of Applicant: _____ Date: _____

PLEASE DO NOT WRITE BELOW THIS LINE – FOR OHS USE ONLY

_____ IPPD #1 _____ Results(mm)_____ Date read_____

_____ IPPD # 2 _____ Results(mm)_____ Date read_____

*Chest X-Ray: _____ Results: _____

QUANTEFERON*: Yes No DATE AND RESULTS: _____

History for PPD Positive Employees

- 1) Birthplace _____
- 2) History of BCG _____
- 3) History of prior TB testing _____
- 4) History of prior treatment _____
- 5) History of TB contacts _____
- 6) Plan: _____

*If Indicated/Documentation required

Immunizations:

_____ Tdap Other: _____

NAME: (Last) _____ (First) _____

HISTORY AND PHYSICAL

B/P _____ PULSE _____ HEIGHT. _____ WEIGHT _____

(Check the following statements for accuracy. Cross out the incorrect statements and indicate the observed abnormalities in the space below)

General Appearance, demeanor, gait, and station are within normal limits.

There is no significant skin eruption.

There is no significant lymphadenopathy.

Lungs are clear to percussion and auscultation.

There are no abnormalities of the breasts.

No cardiac murmurs are audible.

No abdominal mass or organ enlargement is evident.

No hernia is present.

No tenderness or deformity of the back is evident.

There is no sign of drug or alcohol abuse.

No other significant abnormalities are noted.

Provider's comments on affirmative responses:

A physical examination has been performed on this employee and no evidence of significant contagious illness or other disability that would interfere with his/her anticipated responsibilities have been noted.

Provider's Signature

Date

It is the responsibility of the examining physician to ascertain that each patient is informed of any significant problem noted, whether disqualifying or not, and to suggest the means of obtaining appropriate medical attention.