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?: _____

		YES	NO
1.	Do you have any allergies? (check) ☐ medication ☐ seasonal ☐ Latex ☐ 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) _____

		YES	NO
12.	Have you ever had high blood pressure (hypertension)?	____	____
13.	Have you ever been prescribed medication or a special diet for your blood pressure?	____	____
14.	Do you have diabetes?	____	____
15.	Do you have sickle cell disease or trait?	____	____
16.	Have you been out of the continental United States in the past two years?	____	____
17.	Do you have eczema or any skin disease?	____	____
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: _____

Have you had?	**YES**	**NO**
rubella	____	____
measles	____	____
mumps	____	____
tuberculosis	____	____
chicken pox/varicella	____	____
rheumatic fever	____	____
heart disease	____	____
back pain/problem	____	____
hepatitis	____	____
seizure disorders	____	____

Do you currently have?	**YES**	**NO**
asthma	____	____
anemia	____	____
arthritis	____	____
hernia	____	____
back pain/problem	____	____
seizure disorders	____	____
vision problems	____	____
hearing problems	____	____
immune deficiency	____	____
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

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A safe and effective vaccine is available cost free to hospital employees 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.