MEMORIAL HERMANN

Memorial Hermann Health System
Employee Health Medical History Questionnaire

Name: (First, MI, Last)	DOB:	☐ M ☐ F
Phone Number:	Employee ID:	
Address:	City, State, & Zip:	
Position/Dept.:	Campus Site:	

PERSONAL HEALTH HISTORY

Allergies ☐ None Have you had an anaphylactic reaction in which you needed emergency attention? ☐ YES ☐ NO

	Type Of Reaction:		Type Of Reaction:
☐ 2-Phenoxyethanal :		☐ Beef protein:	
☐ Aluminum Hydroxide:		☐ Eggs:	
☐ Amphotericin-B:		☐ Fish/Shellfish:	
☐ Latex:		☐ Milk, Lactose, or Casein:	
☐ Formaldehyde:		☐ Peanuts or Legumes:	
☐ Mercury/Thimerosal:		☐ Seeds:	
☐ Neomycin or Streptomycin:		☐ Tree Nuts:	
☐ Penicillin:		☐ Wheat:	
☐ Phenol:		☐ Yeast:	
☐ Polymyxin:		☐ Bee stings:	
☐ Sulfa:		☐ History of Hives or Urticaria:	

Allergies to other medications, foods or agents not listed above:	Type of Reaction

Current Medications (Prescriptions, Over The Counter, Supplements) ☐ None

Name	Strength	Frequency	Prescription Number	Pharmacy Number
1.				
2.				
3.				
4.				
5.				

Hospitalizations / Surgeries ☐ None

Year	Reason	Year	Reason

Are you currently under treatment for any medical condition? ☐ Yes ☐ No

Have you ever had any of the following OR received medical treatment for? (Check all that apply) ☐ None

☐ Angina / Chest Pain	☐ Cancer	☐ Epilepsy	☐ High Blood Pressure	☐ Stroke
☐ Anxiety	☐ Diabetes	☐ Heart Attack	☐ HIV / AIDS	☐ Tuberculosis
☐ Asthma	☐ Emphysema	☐ Hepatitis		

List any other medical condition not listed above:

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Have you ever had an injury to any of the following body part(s)? (Check all that apply) ☐ None			
☐ Ankle	☐ Head	☐ Knee	☐ Shoulder
☐ Back	☐ Hip	☐ Neck	☐ Wrist
☐ Hand / Finger	☐ Other (specify):		
Please provide date / details of each injury:			

Tobacco History		
Do you currently smoke?	☐ Yes ☐ No If yes, how many packs per day?_____	How many years have you been smoking?_____
Have you every smoked in the past?	☐ Yes ☐ No If yes, how many packs per day?_____	When did you quit?_____
Do you use other forms of tobacco:		
Vaping?	☐ Yes ☐ No If yes, how many times per day?_____	
Pipes?	☐ Yes ☐ No If yes, how many times per day?_____	
Cigars?	☐ Yes ☐ No If yes, how many times per day?_____	
Chewing tobacco?	☐ Yes ☐ No If yes, how many times per day?_____	
Nicotine patch?	☐ Yes ☐ No	

Immunization History

Your immunization history is an important part of your total health and is important to protect the patients we serve. You are required to submit a full copy of your immunization records to the following:

1) Bring your copy to your visit with Employee Health 2) Email copy to iwork@memorialhermann.org

If you do not have a copy of your immunization records, please indicate so here: ☐

Are you currently registered with the state of Texas immunization database (ImmTrac)? ☐ Yes ☐ No

Required Immunizations For Health Care Personnel

☐ Hepatitis A Date(s):_____	☐ Influenza Date(s):_____	☐ MMR (Measles, Mumps, Rubella) Date(s):_____	☐ Shingles Date(s):_____	☐ Varicella Date(s):_____
☐ Hepatitis B Date(s):_____	☐ Meningitis Date(s):_____	☐ Pneumococcal Date(s):_____	☐ Tetanus / Diptheria / Pertussis Date(s):_____	

Are you aware if you have had a non-response to a vaccine? ☐ Yes ☐ No

If yes, please provide which vaccine:_____

Have you... ever fainted from having injection or blood drawn?		☐ Yes ☐ No
ever had a fever after receiving a vaccination?		☐ Yes ☐ No
ever had any other bad reaction or side effect from a vaccination?		☐ Yes ☐ No
If yes, which vaccination?	What type of reaction?	
Do you... have an immune disorder, such as AIDS, Leukemia, or Cancer?		☐ Yes ☐ No
have close contact with anyone having an immune disorder? (Leukemia, Cancer, HIV)		☐ Yes ☐ No
have a family history of immunodeficiency?		☐ Yes ☐ No
Have you received a blood transfusion/blood products/immune globulin in the past 12 months?		☐ Yes ☐ No
Are you pregnant or planning pregnancy within 3 months?		☐ Yes ☐ No

Tuberculosis

Have you ever had a positive test? ☐ Yes ☐ No If yes, when and what kind of test was it (e.g. positive ☐ TB blood test or positive ☐ TB skin test)?

Did you receive treatment? ☐ Yes ☐ No What kind of treatment and for how long?

Were you a resident of or have you ever been to any country OTHER THAN the United States, Canada, Australia, New Zealand and those in Northern Europe or Western Europe? ☐ Yes ☐ No If yes, when and for how long?_____

Have you been in close, prolonged contact with an individual or family member who was diagnosed with infectious TB? ☐ Yes ☐ No

Have you been involved in a known/confirmed job-related exposure to TB? ☐ Yes ☐ No If so, when? _____

Have you ever had the BCG vaccine? ☐ Yes ☐ No

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I certify that the statements on this form are true and complete to the best of my knowledge. I understand that any misstatement or omission on this medical history questionnaire is cause for termination of my employment. Should I be referred to a Physician for further consultation I understand my employment offer will be suspended pending final results and expenses are my responsibility.

☐ AM
☐ PM

Employee Signature	Print Name	Date	Time

PLEASE DO NOT WRITE BELOW THIS LINE.

EMPLOYEE HEALTH NOTES:

_____

_____

_____

_____

Reviewed by: Date:_____

☐ AM
☐ PM

Employee Signature	Print Name	Date	Time

☐ AM
☐ PM

Employee Health Provider Signature	Print Name	NPI/MHHS ID.	Date	Time	Contact No.

EMPLOYEE DRUG TESTING CONSENT FORM

1. I understand that I am being asked to provide a specimen for testing to determine if I have used drugs. I UNDERSTAND THAT I DO NOT HAVE TO PROVIDE SUCH A SPECIMEN IF I CHOOSE NOT TO DO SO, BUT THAT MY REFUSAL MAY RESULT IN DISCIPLINARY ACTION INCLUDING IMMEDIATE DISCHARGE.

2. I hereby give consent to and authorize MHHS and its agents, servants, employees, and/or physicians chosen by MHHS to take a specimen and to use such specimen in any manner MHHS and its agents, servants, employees and physicians deem appropriate including, but not limited to, releasing such specimen to a testing laboratory, hospital, other person or service for testing. I hereby give consent to and authorize MHHS and its agents, servants, employees, and/or physicians chosen by MHHS and any such testing laboratory, hospital, person, or service to conduct drug tests or other information concerning the specimen to MHHS, or to any person or firm designated by MHHS. I hereby release MHHS, its officers, agents, employees and/or physicians chosen by MHHS from any and all claims or liability arising out of or relating to the enforcement of its Substance Abuse Policy, specifically including, but not limited to, all claims for injuries to my person, or damage to my reputation resulting from drug testing, or the release of information concerning such testing.

_____ I CONSENT TO PROVIDE A SPECIMEN FOR USE IN THE MANNER DESCRIBED HEREIN.

_____ I REFUSE TO PROVIDE A SPECIMEN.

_____ _____

Employee Signature **Date**

_____

Employee PRINT NAME

_____ _____

Witness Signature **Date**

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Employee Drug Testing Consent Form

APPLICANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Employment substance abuse screening is a key component of the MHHS applicant selection/employment process. The screening is for both drugs and alcohol. You are requested to list below any prescription or over the counter drugs which you are presently taking or have taken in the past 14 days. Include any kind of capsule, pill, or medication regardless of type. If the drug was prescribed by a physician, include the physician's name. If the drug screen reveals evidence of a drug you neglected to disclose, it could result in failure to qualify for employment. If you have taken no such drugs, please write "none" in the space below. If you fail the substance abuse screen, you may not reapply for employment within 1 year from the date of your drug and alcohol test.

During the employment screening process, information pertinent to the results of the drug screen will be communicated to Occupational Health, and as appropriate, other medical personnel.

CURRENT MEDICATIONS (prescriptions, over the counter, supplements)				☐ **None**
Name	Strength	Frequency	Prescription Number	Pharmacy Number
1.				
2.				
3.				
4.				
5.				

I have carefully read the above explanation of MHHS's employment drug screening procedure. I authorize MHHS to contact my physician to confirm medical prescriptions. If necessary, I understand and agree that failure to pass the required exam, which includes a drug screen, will exclude me from further consideration of employment.

_____ _____

Applicant Signature **DATE**

_____

PRINT YOUR NAME CLEARLY

MEMORIAL HERMANN

NOTICE OF NO WORKERS' COMPENSATION INSURANCE COVERAGE

COVERAGE: **Memorial Hermann Healthcare System, Memorial Hermann Hospital System, Memorial Hermann Medical Group, MHMD, MHealth, Inc., Memorial Hermann Health Ventures, Inc., MH Physicians of Texas, and Memorial Hermann Community Benefit Corporation** have elected not to obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Texas Department of Insurance, Division of Workers' Compensation has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Workers' Health & Safety at 1-800-452-9595.

COBERTURA: **Memorial Hermann Healthcare System, Memorial Hermann Hospital System, Memorial Hermann Medical Group, MHMD, MHealth, Inc., Memorial Hermann Health Ventures, Inc., MH Physicians of Texas, and Memorial Hermann Community Benefit Corporation** ha elegido no obtener cobertura de compensacion para trabajadores. Como empleado de un usted no es elegible para recibir beneficios de compensacion bajo la Ley de Compensacion para Trabajadores de Texas. Sin embargo, un empleador sin cobertura puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener informacion acerca de la disponibilidad de otros beneficios o compensacion por una lesion o enfermedad relacionada con el trabajo. Ademas, usted puede tener derechos bajo la ley de "Derecho Comun" de Texas, si usted ha sufrido una lesion o enfermedad relacionada con su trabajo. Es requerido que su empleador le proporcione informacion acerca de la cobertura, por escrito, cuando es contrado o cuando su empleador obtiene o deja de tener cobertura de seguros de compensacion para trabajadores.

LINEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS: Departmento De Seguros de Texas, Division De Coompensacion Para Trabajadores ha establecido una linea telefonica gratuita las 24 horas, para reporter condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohibe que los empleadores suspendan, despidan o discriminen contra un empleado o empleada porque el o ella, de Buena fe, reporta una presunta violacion ocupacional de salud o seguridad. Comuniquese con la Seccion de Seguridad y Salud al telefono 1-800-452-9595.

I have read and understand the above notice.

He leido y entiendo esta notificacion.

EMPLOYEE:
EMPLEADO:_____

EMPLOYER:
PATRON:_____

DATE:
FECHA:_____

MEMORIAL HERMANN

OSHA Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in section 2 of Part A, do not require medical examination.

To the employee: Can you read (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1 (**Mandatory**) The following information must be provided by every employee who has been selected to use any type of respirator (**PLEASE PRINT**).

1. Todays date: _____
2. Your Name: _____
3. Your Age (to the nearest year): _____
4. Sex (Check One): ☐ Male ☐ Female
5. Your Height: _____Ft. _____In.
6. Your Weight: _____
7. Your Job Title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the heath care professional who will review this questionnaire (Check one) ☐ Yes ☐ No
11. Check the type of respirator you will use (you can check more than one category):
    a. ☐___ Disposable respirator (i.e., N95 or N100 (HEPA) TB respirator (filter-mask, non-cartridge type only)
    b. ☐___ Other type (for example, half- or full – facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus (SCBA). Check the approriate type(s).
12. Have you worn a respirator (check one): ☐ Yes ☐ No If "yes", what type(s): _____

Part A. Section 2. (**Mandatory**) Questions 1 through 9 below **must** be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? ☐ Yes ☐ No
2. Have you ***ever had*** any of the following conditions?
    a. Seizures (fits): ☐ Yes ☐ No
    b. Diabetes (sugar disease): ☐ Yes ☐ No
    c. Allergic reactions that interfere with your breathing? ☐ Yes ☐ No
    d. Claustrophobia(fear of closed–in places): ☐ Yes ☐ No
    e. Trouble smelling odors: ☐ Yes ☐ No
3. Have you ***ever had*** any of the following pulmonary or lung problems?
    a. Absestosis ☐ Yes ☐ No
    b. Asthma ☐ Yes ☐ No
    c. Chronic Bronchitis ☐ Yes ☐ No
    d. Emphysema ☐ Yes ☐ No
    e. Pneumonia ☐ Yes ☐ No
    f. Tuberculosis ☐ Yes ☐ No
    g. Silicosis ☐ Yes ☐ No
    h. Pneumothorax (collapsed Lung) ☐ Yes ☐ No
    i. Lung Cancer ☐ Yes ☐ No
    j. Broken Ribs ☐ Yes ☐ No
    k. Any chest injuries or surgeries ☐ Yes ☐ No
    l. Other lung problems that you've been told about? ☐ Yes ☐ No

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: ☒ Yes ☒ No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: ☐ Yes ☐ No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: ☐ Yes ☐ No
   d. Have to stop for breath when walking at your own pace on level ground: ☐ Yes ☐ No
   e. Shortness of breath when washing or dressing yourself: ☐ Yes ☐ No
   f. Shortness of breath that interferes with your job: ☐ Yes ☐ No
   g. Coughing that produces phlegm (thick sputum): ☐ Yes ☐ No
   h. Coughing that wakes you early in the morning: ☐ Yes ☐ No
   i. Coughing that occurs mostly when you are lying down: ☐ Yes ☐ No
   j. Coughing up blood in the last month: ☐ Yes ☐ No
   k. Wheezing: ☐ Yes ☐ No
   l. Wheezing that interferes with your job: ☐ Yes ☐ No
   m. Chest pain when you breathe deeply: ☐ Yes ☐ No
   n. Any other symptoms that you think may be related to lung problems: ☐ Yes ☐ No

5. Have you ***ever had*** any of the following cardiovascular or heart problems?
   a. Heart attack: ☐ Yes ☐ No
   b. Stroke: ☐ Yes ☐ No
   c. Angina: ☐ Yes ☐ No
   d. Heart failure: ☐ Yes ☐ No
   e. Swelling in your legs or feet (not caused by walking): ☐ Yes ☐ No
   f. Heart arrhythmia (heart beating irregularly) ☐ Yes ☐ No
   g. High blood pressure: ☐ Yes ☐ No
   h. Any other heart problem that you've been told about: ☐ Yes ☐ No

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: ☐ Yes ☐ No
   b. Pain or tightness in your chest during physical activity: ☐ Yes ☐ No
   c. Pain or tightness in your chest that interferes with your job: ☐ Yes ☐ No
   d. In the past two years, have you noticed your heart skipping or missing a beat: ☐ Yes ☐ No
   e. Heartburn or indigestion that is not related to eating: ☐ Yes ☐ No
   f. Any other symptoms that you think may be related to heart or circulation problems: ☐ Yes ☐ No

7. Do you **currently** take medication for any of the following problems?
   a. Breathing or lung problems ☐ Yes ☐ No
   b. Heart trouble: ☐ Yes ☐ No
   c. Blood pressure: ☐ Yes ☐ No
   d. Seizures (fits): ☐ Yes ☐ No

8. **If** you've used a respirator, (TB Mask) have you ever had any of the the following problems?
   (If you've never used a respirator, go to question 9)
   a. Eye irritation: ☐ Yes ☐ No
   b. Skin allergies or rashes: ☐ Yes ☐ No
   c. Anxiety: ☐ Yes ☐ No
   d. General weakness or fatigue: ☐ Yes ☐ No
   e. Any other problem that interferes with your use of a respirator: ☐ Yes ☐ No

9. Would you like to talk to the health care professional that will review the questionnaire? ☐ Yes ☐ No

To the best of my knowledge, the information I have provided is true and accurate.

_____ _____

Employee Signature **Date**

Occupational Health Use Only

_____ Employee cleared for fit testing _____ Employee clearance pending medical director review.

_____ Employee referred to personal physician Mask Mfg/ Mdl/ Sz _____ / _____ / _____

____Failed ____ Pass _____Fit Factor Signature: _____ **Date**: ___/___/_____