



MEDICAL HISTORY QUESTIONNAIRE

Name: (First, MI, Last)		DOB:	<input type="checkbox"/> M <input type="checkbox"/> F
SS#:	Employee ID:		
Address:	Position/Department:		
	Phone Number:		

PERSONAL HEALTH HISTORY

LATEX ALLERGY: YES NO If yes, type of reaction:
 First Occurrence: Under Treatment:

ALLERGIES TO MEDICATIONS OR OTHER AGENTS	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

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

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Depression	<input type="checkbox"/> Rubella (German)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Measles (Red)
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Chickenpox
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Angina / Chest Pain	<input type="checkbox"/> Mumps	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Alcohol or Drug Dependency / Abuse		<input type="checkbox"/> Tuberculosis	

List any other medical condition not listed above:

Have you ever had an injury to any of the following body part(s)? (Check all that apply)

<input type="checkbox"/> Back	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Knee
<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand / Finger	<input type="checkbox"/> Neck
<input type="checkbox"/> Ankle	<input type="checkbox"/> Head	<input type="checkbox"/> Hip
<input type="checkbox"/> Other (specify):		

Please provide date / details of each injury:

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TOBACCO HISTORY

Do you currently smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how many packs per day?
	How many years have you been smoking?
Have you ever smoked in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how many packs per day?
	When did you quit?
Do you use other forms of tobacco:	
Vaping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how many times per day?
Pipes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how many times per day?
Cigars?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how many times per day?
Chewing tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how many times per day?

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:

Required Immunizations For Health Care Personnel

Hepatitis B	Varicella	Tetanus / Diphtheria / Pertussis
MMR (Measles, Mumps, Rubella)	Meningitis	Influenza

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

If yes, please provide which vaccine:

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

ALLERGIES

<input type="checkbox"/> Eggs	<input type="checkbox"/> 2-Phenoxyethanal	<input type="checkbox"/> Aluminum Hydroxide	<input type="checkbox"/> Amphotericin-B
<input type="checkbox"/> Yeast	<input type="checkbox"/> Mercury / Thimerosal	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Polymyxin
<input type="checkbox"/> Gelatin	<input type="checkbox"/> Neomycin or Streptomycin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> None
<input type="checkbox"/> Bee stings or history of Hives or Urticarial		<input type="checkbox"/> Beef protein, soy, lactose, phenol, casein, or formaldehyde	
Other allergies not listed above:			



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

TUBERCULOSIS	
Have you ever had a positive test? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when:
Did you receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	What kind of treatment?
Date of most recent chest X-ray:	Chest X-ray result:
Have you had BCG? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide date:

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.

Signature

PLEASE DO NOT WRITE BELOW THIS LINE.

EMPLOYEE HEALTH NOTES:

Reviewed by: _____

Date: _____



NOTICE OF NO WORKERS' COMPENSATION INSURANCE COVERAGE

COVERAGE: Memorial Hermann Health System, Memorial Hermann Hospital System, MHMG, MHMD, Memorial Hermann Health Insurance, Memorial Hermann Employer Solutions, 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 Health System, Memorial Hermann Hospital System, MHMG, MHMD, Memorial Hermann Health Insurance, Memorial Hermann Employer Solutions, 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 contratado o cuando su empleador obtiene o deja de tener cobertura de seguros de compensacion para trabajadores.

LINEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS: Departamento 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 prohíbe 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 leído y entiendo esta notificación.

EMPLOYEE:
EMPLEADO: _____

EMPLOYER:
PATRON: _____

DATE:
FECHA: _____