

HEALTH HISTORY QUESTIONNAIRE

Legal Name _____

Date of Birth _____

Preferred Name _____

Phone Number _____

Pronouns _____

(Example: she/her he/him they/them etc.)

Prefer not to disclose

Job Title _____

Department _____

Why we collect this information

Your health and safety are important to us. The Employee Health & Safety (EH&S) Departments at Samaritan Health Services serves you, the employee, so that you can provide care and services to our patients. Working in healthcare can present certain risks and hazards. We obtain an abbreviated health history when you begin employment to establish a baseline assessment of your health status. This is an essential component of occupational health and safety and assists us with being proactive to support you in preventing on-the-job injuries or illnesses and to protect the safety of our patients and your coworkers. Proactive measures could include worksite ergonomic evaluations, providing alternative hand hygiene products or recommending specialty personal protective equipment.

If you do sustain an on-the-job injury or illness and visit one of the EH&S offices, we will have your baseline health history on file to facilitate care with an Employee Health (EH) nurse and to assist with a referral for further treatment if needed. In addition to injury/illness care, the EH nurse can advocate for you in matters pertaining to accommodations and fitness-for-duty evaluations.

NOTE: This health history questionnaire will be maintained in your employee health record. Your employee health record is separate from your HR employment record. Your employee health record is not available through Epic and is not shared with your personal health information (PHI) records. SHS EH&S complies with the strict confidentiality requirements of the Oregon Occupational Safety and Health Administration (OR-OSHA). Managers do not have access to the employee's health record.

If you have any questions or concerns regarding the New Hire Health Screening Questionnaire, please contact us at HRServiceCenter@samhealth.org.

Health History

1. List allergies and reactions to any medication, food, latex, or other substance:

No Yes

2. Restrictions:

- a. Do you have any work restrictions? If yes, please provide a copy of all work restrictions from your health care provider.
- b. Do you have any medical conditions or disabilities that may affect your ability to perform the requirements of your job? If yes, please describe:

3. Thank you for taking the time to complete this form. If there is anything else you wish to share or discuss, please speak with your Employee Health Nurse.

Employee Signature _____

Date _____

Instructions: Upon completing form, return to [SHS HR Service Center](#).

Employee Health & Safety Use Only

Notes:

Reviewed By _____

Date _____

Not part of the medical record. Do not scan into EMR. Return to SHS Employee Health and Safety

TUBERCULIN (TB) SCREENING FORM

Name _____

Date of Birth _____

Phone Number _____

Employee # _____

Job Title _____

Department _____

No Yes

1. Have you ever had a Tuberculin Skin Test (TST) or TB blood test? *If yes, date of last one:* _____ *Result:* _____

2. Have you ever had a positive TST/QuantIFERON blood test? *If yes, date:* _____ *Last chest x-ray:* _____

3. Have you ever been diagnosed with TB? *If yes, year:* _____

4. Have you previously completed preventative therapy (INH) or treatment for TB? *If yes, year?* _____

Medication: _____ *Duration:* _____

5. Do you have any of the following conditions that will increase your risk of TB disease?

Hematologic & reticuloendothelial disease (e.g., Leukemia, Hodgkin's disease)	End stage renal disease	Exposure to TB-infected persons	Chronic malabsorption syndromes
Silicosis	Rheumatoid Arthritis	Cancer of head/neck	Immunosuppressive treatment
Low body weight	Recent TB infection	Crohn's	Substance abuse
HIV infection		Diabetes mellitus	Organ transplant

6. Do you have any of the following systemic symptoms of TB?

Fever/chills	Night sweats	Easy fatigability	Chest pain
Loss of appetite	Weight loss	Productive cough	Bloody sputum

7. Where were you born? USA Other country: _____ Year of arrival to USA: _____

8. Have you lived or traveled outside of the USA in the last 2 years? *If yes, list countries:* _____

9. Have you lived or worked in a correctional facility, homeless shelter, or residence with AIDS patients?

10. Have you had unprotected exposure to anyone with suspected or diagnosed TB?

11. Have you received any live vaccines in the last four weeks? (e.g., MMR, Varicella, Flu Mist, Typhoid)

Explanation to any "Yes" statements above or other comments:

Signature _____

Date _____

Instructions: Upon completing form, return to [SHS HR Service Center](#).

FOR OFFICE USE ONLY			
Baseline	<input type="checkbox"/> Risk Factor Screening	<input type="checkbox"/> Exposure Baseline	Exposure Follow-up Other _____
Employee Health Nurse _____	Date _____		
Comments _____			

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 a medical examination.

To the Employee:

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. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex: Male Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire:
 Yes No
11. Check the type of respirator you will use (you can check more than one category):
 N, R, or P disposable respirator (*filter-mask, non-cartridge type only*)
 Other type (*for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus*).
12. Have you worn a respirator: Yes No
If yes, what type(s): _____

Part A. Section 2. (Mandatory)

Questions 1-9 below must be answered by every employee who has been selected to use any type of respirator (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**?

	Yes	No		Yes	No
a. Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>	d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>	e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>			

3. Have you *ever had* any of the following **pulmonary or lung problems**?

	Yes	No		Yes	No
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>			

4. Do you *currently* have any of the following **symptoms of pulmonary or lung illness**?

	Yes	No		Yes	No
a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>	i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>	j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>	k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>	m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>	n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you <i>ever had</i> any of the following cardiovascular or heart problems ?					
	Yes	No		Yes	No
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>	g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you <i>ever had</i> any of the following cardiovascular or heart symptoms ?					
	Yes	No		Yes	No
a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>	d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>	e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>	f. Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you <i>currently</i> take medication for any of the following problems ?					
	Yes	No		Yes	No
a. Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	c. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	d. Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>
8. If you've used a respirator, have you <i>ever had</i> any of the following problems ? (If you've never used a respirator, check the following box and go to question 9): <input type="checkbox"/> Never used a respirator					
	Yes	No		Yes	No
a. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>	d. General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>	e. Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>			
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire: <input type="checkbox"/> Yes <input type="checkbox"/> No					

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever lost vision* in either eye (temporarily or permanently): Yes No

11. Do you *currently* have any of the following **vision problems**?

	Yes	No		Yes	No
a. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	c. Color blind	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	d. Any other eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/>

12. Have you *ever had* an injury to your **ears**, including a broken ear drum? Yes No

13. Do you *currently* have any of the following **hearing problems**?

	Yes	No		Yes	No
a. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	c. Any other hearing or ear problem	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>			

14. Have you *ever had* a **back injury**? Yes No

15. Do you *currently* have any of the following musculoskeletal problems?

	Yes	No		Yes	No
a. Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/>	<input type="checkbox"/>	f. Difficulty fully moving your head side to side	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	g. Difficulty bending at your knees	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty fully moving your arms and legs	<input type="checkbox"/>	<input type="checkbox"/>	h. Difficulty squatting to the ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Pain or stiffness when you lean forward or backward at the waist	<input type="checkbox"/>	<input type="checkbox"/>	i. Climbing a flight of stairs or a ladder carrying more than 25 pounds	<input type="checkbox"/>	<input type="checkbox"/>
e. Difficulty fully moving your head up or down	<input type="checkbox"/>	<input type="checkbox"/>	j. Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/>	<input type="checkbox"/>

Part B. Additional Questions

- | | Yes | No | Don't know |
|--|--------------------------|--------------------------|--------------------------|
| 1. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? If "yes" list the medications if you know them: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Will you be using any of the following items with your respirator(s)? | | | |
| a. HEPA Filters | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Canisters | | | |
| c. Cartridges | | | |
| 3. During the period you are using the respirator(s) is your work effort: | | | |
| a. Light (less than 200 kcal per hour) – If "yes" how long does this period last during the average shift: _____ hours _____ minutes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Moderate (200 to 350 kcal per hour) – If "yes" how long does this period last during the average shift: _____ hours _____ minutes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Heavy (above 350 kcal per hour) – If "yes" how long does this period last during the average shift: _____ hours _____ minutes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? If "yes" describe this protective clothing and/or equipment: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Describe the work you'll be doing while you're using your respirator(s): _____
_____ | | | |

Signature: _____

Date: _____

Respirator Clearance Status

- Healthcare worker able to safely use a respirator without health limitations. Cleared for respirator fit testing and/or training.
- Sufficient information provided by healthcare worker to questions 1-8 (Appendix C. Part A, Section 2) to clear healthcare worker to be fit tested or referred to PAPR training.
- Medical exam required. Referred to Samaritan Occupational Medicine.

PLHCP Signature: _____

Date: _____

PLHCPs: Krisa Gigon, RN Rhea Wood, RN Lisa Wolf, RN

Jill Mackey-Feist, RN Andrea Smithson, RN Ali Young, RN

Other: _____



INFLUENZA VACCINATION STATUS/DECLINATION FORM

Name _____

Date of Birth _____

Personal Phone # _____

Employee # _____

Role	Employee	Locum/Medical Staff	Resident/Fellow	Agency/Contract/Traveler
	Volunteer	Student/Medical Student	Thomas Cuisine	Other _____

Choose one:

I have received this season’s influenza vaccine elsewhere (07/01 – 06/30).

Please provide documentation to [SHS HR Service Center](#) and/or complete the following:

Date Received: _____ Location/Facility: _____

I have a medical contraindication to the influenza vaccine.

Severe, life-threatening allergies to flu vaccine or any ingredient in the vaccine. This might include gelatin, antibiotics, or other ingredients. Talk to your healthcare provider if you have an allergy to any of the ingredients in the vaccine or ever had Guillain-Barré Syndrome (a severe paralyzing illness, also called GBS).

I am declining the seasonal influenza vaccine for a non-medical reason.

Acknowledgement

I acknowledge that I have been offered the influenza vaccination free of charge by my employer because it is recognized by healthcare authorities to be safe and effective in preventing disease.

If declining the influenza vaccination, I understand that I can change my mind at any time and receive the seasonal influenza vaccination, if vaccine is available. I have read and fully understand the information on this form.

I acknowledge and confirm that the above information is correct.

Signature _____

Date _____

Instructions: Upon completing form, return to [SHS HR Service Center](#).

Not part of the medical record. Do not scan into EMR. Return to SHS Employee Health and Safety

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