ANNUAL HEALTH HISTORY QUESTIONNAIRE – 2012

The New York State Department of Health Code and Regulations requires a health examination prior to beginning employment in a healthcare facility with an annual evaluation thereafter. The information requested in this questionnaire is necessary for an accurate evaluation of your past and present health status. **Your compliance with these regulations is necessary for continuing employment at Thompson Health.**

The information provided will be treated in confidence, discussed with the Associate Health Nurse, and placed in your health file. In the event that an associate has a health problem that requires ongoing follow-up or frequent evaluation, the Associate Health Department will communicate with the associate and the Department Manager to ensure proper supervision to prevent any hazard or risk to patients, residents, participants, guests, and other associates. Any further communication about any of the information furnished will be provided to the Department Manager or Administration only after consultation with the associate.

If an associate is involved in an accident or illness at work covered under Worker's Compensation, any pertinent information necessary for evaluation of the Associate's health status prior to or at the time of the accident/illness will be provided by FFTH to the Worker's Compensation Board upon their request.

Thank you for your cooperation and prompt attention to this yearly requirement.

Last Name First Name MI Maiden

Address City State Zip Phone # Cell #

Birth Date Age Sex Department Extension Physician

Person to Contact in an Emergency Relationship

Emergency Contact Address Phone # Cell Phone #

In your opinion, your general health status is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

If you work in Long Term Care, you are eligible to receive a Pneumonia Vaccine if you are over 65 or have a chronic health condition (alcoholism, heart or lung disease, kidney failure, diabetes, HIV infection or cancer.) This is recommended by the New York State Department of Health. Would you like to receive a pneumonia vaccine? ❑Yes ❑No

Have you had any changes in your health or developed any new problems in the LAST year? ❑Yes ❑No
If yes, explain: _____

Have you been to your Primary Care Physician or seen a Specialist in the LAST year for other than a routine visit? ❑Yes ❑No
IF YES, REASON _____

Have you visited the Emergency Department for any reason in the LAST year? ❑Yes ❑No
IF YES, REASON: _____

Have you been admitted to a hospital in the LAST year? ❑Yes ❑No
IF YES, DATES, REASON: _____

Have you had any medical testing or procedures done in the LAST year? ❑Yes ❑No
IF YES, LIST: _____

Are you allergic to any medications? ❑Yes ❑No
If yes, list: _____

Are you currently taking any medications? ❑Yes ❑No
IF YES, LIST: _____

Have you received a Tetanus Booster in the past 10 years? ❑Yes ❑No If yes, date: _____

Have you been exposed to someone with Hepatitis in the LAST year? ❑Yes ❑No
If yes, date and type of Hepatitis: _____
Did you use appropriate isolation precautions? ❑Yes ❑No
Was the exposure reported to Associate Health? ❑Yes ❑No

Do you have any skin rashes or irritations that do not clear up or frequently reoccur? ❑Yes ❑No
If yes, explain: _____

Have you had serious diarrhea (more than 48 hours/blood/mucous) in the LAST year? ❑Yes ❑No
If yes, explain: _____

How many days have you been out of work due to illness or injury in the LAST year? _____
Reasons: _____

Do you have a vision problem? ❑Yes ❑No If yes, is it corrected? ❑Yes ❑No
Do you wear contact lenses? ❑Yes ❑No
Do you have a hearing problem? ❑Yes ❑No If yes, is it corrected? ❑Yes ❑No

Do you have any impairment that may be of potential risk to the patients, residents, or associates at Thompson Health or that may interfere with your performance of job duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or any substance that may alter your behavior? ❑Yes ❑No

(A yes response will not necessarily lead to any employment action, although the matter may have to be explored further on a confidential basis to determine whether the impairment is one that would impact your ability to perform your essential job duties in a satisfactory manner, and, if not, whether there is a reasonable accommodation that would allow you to do so.)

If yes, explain: _____

Do you smoke? ❑Yes ❑No
Would you like information to help stop smoking? ❑Yes ❑No

Do you have any questions or concerns in regard to your current health? ❑Yes ❑No

If yes, explain: _____

All of the above information is true to the best of my knowledge. I understand that falsely reporting any health information may result in immediate termination of employment with Thompson Health.

_____
Signature of Associate Date

_____
Signature of Associate Health Nurse Date

Office Use Only(Complete at time of Health Update):

BP_____ P_____ Wt _____ Other _____

Please Note: Associates may view their own health information at any time.
This request must be given in writing to the Associate Health Office.
Thompson Health is proud to be an equal opportunity employer