EMPLOYEE HEALTH SERVICES
ANNUAL EMPLOYEE MEDICAL EVALUATION

Name: _____ Date: _____

Employee Number: _____ DOB: _____

Home Telephone: _____ Cell Phone: _____

Emergency Contact:

Name:_____ Telephone Number: _____ Relationship:_____

Name:_____ Telephone Number: _____ Relationship:_____

Disclaimer: The information collected during your annual visit is for your benefit and protection. This information is protected by HIPAA and will not be shared with anyone outside of Employee Health Services.

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1. Allergies: _____
2. Latex Allergies: _____
3. **Please List Current Medications:** (Some medications affect ones ability to perform essential functions of a job.) If additional space is needed, please use back of form.
4. _____
   _____
   _____
5. Vision or Hearing Changes: Please describe: _____
   _____
6. Medical History: List any new or existing physical/psychological limitations that may prevent you from performing the essential functions of your job.
   _____
   _____
7. Do you have high blood pressure?_____
8. If yes, is it controlled with medications?
   _____
9. Have you sustained any new injuries in the last year?
   _____
10. If yes, please describe.
    _____
11. Have you had any surgeries in the last year?
    _____

FIT TEST EVALUATION

NAME _____ DATE_____ DOB_____

MANAGER_____ EMPLOYEE #_____ DEPT: _____

When respiratory protection is required and respirators are issued to employees, OSHA requires Fit Testing be conducted as part of that annual respiratory protection program. To ensure your N95 Particulate Filter Respirator provides the intended level of protection, it is important that the respirator is applied properly and that a FIT CHECK is performed each and every time you wear it.

In addition to annual fit testing, re-evaluation will be necessary, whenever the wearer undergoes changes that could alter facial structure, such as facial surgery or a significant change in body weight.

	YES	NO
1. Have you ever experienced any medical conditions i.e., Cardiopulmonary conditions, claustrophobia or allergies to mask materials that would make it difficult for you to perform your duties while wearing a mask?		
2. Are you allergic to saccharin?		
3. Are you short of breath?		
4. Do you get short of breath when walking or at work?		
5. Do you get chest pain with certain activities?		
6. Do you have medical issues that might interfere with N95 mask use?		
7. Have you ever had a problem wearing an N95 mask?		
8. Do you currently smoke?		
9. Are you an ex-smoker?		
Comments:		

EMPLOYEE SIGNATURE: _____

DO NOT WRITE BELOW THIS LINE: CLINIC USE ONLY

Limitations:	___ Beard ___Glasses ___None
Fitting:	___ Satisfactory Qualitative Saccharin Fit Test
Instruction for use:	___ Reviewed ___ Donning/Removal ___ Storage/Replacement
Saccharin Fit Test:	___ Pass ___Fail
Respirator Size:	___ Small ___ Regular Style# _____

TESTER PRINTED NAME: _____ SIGNATURE:_____ _____

CAPE FEAR VALLEY HEALTH

Employment Status

□ Employee □ MD/LIP
□ Student □ Agency
□ Volunteer □ Contractor: _____

Tuberculosis Screening

Name: _____ Date of Birth: _____ Employee ID/SS# _____

Department/Ext: _____ Home/Cell Phone Number: _____ Allergies: _____

☐ Post Offer ☐ Two Step ☐ Annual ☐ 6-month review ☐ Exposure baseline ☐ Post Exposure Follow Up

Signs & Symptoms of Tuberculosis

☐ Yes ☐ No Have you lost unexplainable weight in the last 6 months without dieting? If yes, how much _____
☐ Yes ☐ No Are you experiencing a loss of appetite? If yes, how long? _____
☐ Yes ☐ No Do you, on a regular basis, have unexplainable night sweats or wake up with the sheets wet from sweating? If yes, how long _____
☐ Yes ☐ No Do you have a frequent persistent cough? If yes, how long? _____
☐ Yes ☐ No Are you bothered by being tired all the time? If yes, how long? _____
☐ Yes ☐ No Are you bothered by shortness of breath? If yes, how long? _____
☐ Yes ☐ No Do you cough up blood? If yes, how long? _____
☐ Yes ☐ No Have you been having increased temperature? If yes, how long? _____

Medical History

☐ Yes ☐ No Have you ever had a positive TB Skin or blood test? If yes, year _____
☐ Yes ☐ No Have you ever taken medication to prevent or treat TB, e.g., Isoniazid (INH) or Rifampin?
☐ Yes ☐ No Have you ever had BCG vaccine? If yes, year _____
☐ Yes ☐ No Have you ever had TB disease diagnosis? If yes, year _____
☐ Yes ☐ No Have you had a live virus vaccine in the past 4 weeks? If yes, wait 4 weeks.
☐ Yes ☐ No Have you had a recent viral illness? If yes, wait 2 weeks.
☐ Yes ☐ No Are you taking immunosuppressive drugs? If yes, consider 5mm positive.
☐ Yes ☐ No Do you have any health conditions or take medications that might affect your immune system (e.g., Steroids, HIV/AIDS, organ transplant, chemotherapy, severe chronic illness).

Travel History

☐ Yes ☐ No Were you born in the US? If no, where? _____When did you come to the US? _____
☐ Yes ☐ No Since your last screening, have you traveled outside the country? When/where/how long? _____

I understand if I should experience any of the signs & symptoms of tuberculosis above at any time during the year, I will contact Employee Health immediately.

Employee/Volunteer Signature: _____Date: _____

**********Test Administrator Use Only**********

1st Step TST: Manufacturer: Tubersol Lot #_____ Exp: _____ 0.1 ml Interdermal
Site: Forearm ☐ Right ☐ Left Administered by: _____ Dept: _____ Date: _____
Induration: _____mm Read by: _____ Dept: _____ Date: _____

****

2nd Step TST: Manufacturer: Tubersol Lot #_____ Exp #: _____ 0.1 ml Interdermal
Site: Forearm ☐ Right ☐ Left Administered by: _____ Dept: _____ Date: _____
Induration: _____mm Read by: _____ Dept: _____ Date: _____
IGRA results: ☐ Negative ☐ Positive Sent for CSR: ☐ Yes ☐ No CXR ☐ Negative ☐ Positive

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 (circle one): 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 (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one category):

    a. ___ N, R, or P disposable 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).

12. Have you worn a respirator (circle 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 circle "yes" or "no").

	YES	NO
1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you *ever had* any of the following conditions?	☐	☐
a. Seizures	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you *ever had* any of the following pulmonary or lung problems?	☐	☐
a. Asbestosis	☐	☐
b. Asthma	☐	☐

	YES	NO
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax (collapsed lung)	☐	☐
i. Lung cancer	☐	☐
j. Broken ribs	☐	☐
k. Any chest injuries or surgeries	☐	☐
l. Any other lung problem that you've been told about	☐	☐
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?	☐	☐
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐
5. Have you *ever had* any of the following cardiovascular or heart problems?		
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐

	YES	NO
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about	☐	☐
6. Have you *ever had* any of the following cardiovascular or heart symptoms?	☐	☐
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you *currently* take medication for any of the following problems?	☐	☐
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures	☐	☐
8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9.) ☐	☐	☐
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a respirator	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

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)?	☐	☐
11. Do you *currently* have any of the following vision problems?	☐	☐
a. Wear contact lenses	☐	☐
b. Wear glasses	☐	☐
c. Color blind	☐	☐
d. Any other eye or vision problem	☐	☐

	YES	NO
12. Have you *ever had* an injury to your ears, including a broken eardrum?	☐	☐
13. Do you *currently* have any of the following hearing problems?	☐	☐
a. Difficulty hearing	☐	☐
b. Wear a hearing aid	☐	☐
c. Any other hearing or ear problem	☐	☐
14. Have you *ever had* a back injury?	☐	☐
15. Do you *currently* have any of the following musculoskeletal problems?	☐	☐
a. Weakness in any of your arms, hands, legs, or feet	☐	☐
b. Back pain	☐	☐
c. Difficulty fully moving your arms and legs	☐	☐
d. Pain and stiffness when you lean forward or backward at the waist	☐	☐
e. Difficulty fully moving your head up or down	☐	☐
f. Difficulty fully moving your head side to side	☐	☐
g. Difficulty bending at your knees	☐	☐
h. Difficulty squatting to the ground	☐	☐
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
j. Any other muscle or skeletal problem that interferes with using a respirator	☐	☐

This infosheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

OSHA Educational Materials

OSHA has an extensive publications program. For a listing of free items, visit OSHA's web site at www.osha.gov/publications or contact the OSHA Publications Office, U.S. Department of Labor, 200 Constitution Avenue, N.W., N-3101, Washington, DC 20210. Telephone (202) 693-1888 or fax to (202) 693-2498.

Contacting OSHA

To report an emergency, file a complaint or seek OSHA advice, assistance or products, call (800) 321-OSHA (6742) or contact your nearest OSHA regional, area, or State Plan office; TTY: 1-877-889-5627.

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