CAPE FEAR VALLEY HEALTH

Clear Form

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Cape Fear Valley Health System

Employee Health Annual Visit - History Update

Name: _____ Date: _____

Employee Number: _____

Home Telephone: _____ Cell Phone: _____

Emergency Contact: Please list name, telephone number relationship, ex. Spouse, Friend

_____

Disclaimer: The information collected during your annual visit is for your benefit and protection. This information is protected by HIPPA and will not be shared with anyone. Dependent information is collected in the event of a disaster. Family members as well as employees may need to be treated. Dependant information is also used for EHS to have an accurate count for treatment.

Household Members	**DOB**	**Relationship**
(Data collection necessary in conjunction with Emergency Preparedness Plan)		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies_____

Latex Allergies _____

Please List Current Medications: (Many medications affect ones ability to perform essential functions of a job). If additional space is needed, please use back of form.

_____

Vision or Hearing Changes: Please describe

_____

Medical History: List any new or existing physical /psychological limitations that may prevent you from performing the essential functions of your job.

_____

_____

Print Name: _____Signature:_____

EMPLOYEE HEALTH SERVICES
MEDICAL EVALUATION FOR THE HEPA RESPIRATOR USE

CONFIDENTIAL MEDICAL HISTORY

Have you ever worn a Respirator mask before? ☐ YES ☐ NO

If yes, describe any problems using the respirator: _____

Do you have high blood pressure? ☐ YES ☐ NO

If yes, is it controlled with medications? ☐ YES ☐ NO

Have you ever had a heart attack or any other form of heart disease? ☐ YES ☐ NO

If yes, when did you have a heart attack and are you currently under a doctor's care? ☐ YES ☐ NO

Date and Doctor's name: _____

Do you get chest pain when you exert yourself? ☐ YES ☐ NO

Are you short of breath when exerting, than other persons of your age & weight? ☐ YES ☐ NO

Do you have a chronic cough or other respiratory symptoms from asthma? ☐ YES ☐ NO

Has a physician ever diagnosed you with lung disease? ☐ YES ☐ NO
If yes, what year were you diagnosed_____
If yes, when was your last attack? _____

Do you currently have the following symptoms?
Fainting spells ☐ YES ☐ NO
Irregular heart beat ☐ YES ☐ NO
Night sweats ☐ YES ☐ NO

Do you have any other conditions that might interfere with wearing the Respirator Mask? ☐ YES ☐ NO

Comments and List of medications:
_____

Print Name: _____Signature:_____ Date: _____

Employee #: _____Date of Birth: _____ Dept.: _____

Manager's Name: _____

Do not write below this line - clinic use only

_____

Initial as appropriate
Cleared for Fit Test _____ Any approved method _____Port-a Count only _____
Unable to clear for Fit Testing _____ Smoke only _____Hood only _____