

# UVA-WorkMed Health Medical Questionnaire

Soc Sec# \_\_\_\_\_ History# \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_

Name \_\_\_\_\_ Birth Date: \_\_\_\_\_

Date of Employment \_\_\_\_\_ Job Title \_\_\_\_\_ Dept. \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

1. Have you ever had chickenpox? Please circle one:       **YES**       **NO**       **UNKNOWN**  
If no, have you had the varicella vaccine? If yes, provide medical documentation of month/day/year..... YES NO
2. Have you ever had a rubella titer (German Measles) drawn? If yes, provide documentation of titer result. YES NO
3. Have you ever had mumps?.....YES NO
4. Have you ever had a **measles, mumps and/or rubella vaccine**?  
If yes, provide documentation of dates (month/day/year).....YES NO
5. Have you ever had the tetanus series? If yes, provide documentation of month/day/year. ....YES NO
6. Have you ever had Tdap? If yes, provide documentation of month/day/year. ....YES NO
7. Have you ever had a **reaction (redness and swelling) to a tuberculin skin test**? .....YES NO
8. Have you ever received treatment for latent tuberculosis (i.e. INH therapy)? .....YES NO  
If yes, please give treatment dates \_\_\_\_\_
9. Have you received the **Hepatitis B vaccination series**?  
If yes, provide documentation of dates (month/day/year).....YES NO  
If yes, did you have a titer drawn approximately one to two months after your 3<sup>rd</sup> injection? Provided documentation of titer results.....YES NO
10. Have you ever coughed up blood? .....YES NO
11. Do you sometimes have severe soaking sweats at night?.....YES NO
12. Have you ever had **tuberculosis**? When? .....YES NO
13. Did you ever live with anyone who had tuberculosis? When?.....YES NO
14. Have you ever had **yellow jaundice/hepatitis**? When?.....YES NO
15. Have you ever been told that you have a **chronic liver disease**? .....YES NO
16. Have you ever cultured positive for methicillin-resistant *Staph aureus* (MRSA)?.....YES NO
17. Have you ever cultured positive for vancomycin-resistant enterococcus (VRE)? .....YES NO
18. Have you ever been hospitalized for psychiatric treatment or been advised by a doctor to seek treatment? YES NO
19. Have you ever been addicted to or used drugs illegally? .....YES NO
20. Are you **allergic** to any medication or food, or have any sensitivity to chemicals? Please list: .....

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21. Do you have any **chronic eye conditions**?.....YES NO
22. Do you have trouble identifying colors? .....YES NO
23. Do you have any **loss of hearing**? .....YES NO
24. Do you wear a hearing aid? .....YES NO
25. Do you smoke cigarettes? How many a day?.....YES NO

26. Do you have emphysema, bronchitis or difficulty breathing?.....YES NO
27. Do you have trouble with dizziness, lightheadedness or fainting?.....YES NO
28. Have you ever been told that you have a heart murmur, or any other heart condition?.....YES NO
29. Have you ever had a seizure or convulsion (**epilepsy**)?.....YES NO
30. Have you ever felt you should cut down on your **drinking**?.....YES NO
31. Have people annoyed you by criticizing your drinking?.....YES NO
32. Have you ever felt bad or guilty about your drinking? .....YES NO
33. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?.....YES NO
34. Do you have any chronic illnesses? List: .....YES NO
35. Have you been told by a physician that you have an allergy to any latex product?.....YES NO
- If yes, to what specifically did the physician say you were allergic? \_\_\_\_\_

36. Have you had a reaction to any of the following items within one hour of exposure? Reactions include itching, redness, swelling, hives, runny nose, congestion, wheezing, or chest tightness.

	Yes	No		Yes	No		Yes	No
Adhesive tape	<input type="checkbox"/>	<input type="checkbox"/>	Balloon	<input type="checkbox"/>	<input type="checkbox"/>	Bandage	<input type="checkbox"/>	<input type="checkbox"/>
Dental mask	<input type="checkbox"/>	<input type="checkbox"/>	Condom	<input type="checkbox"/>	<input type="checkbox"/>	Dental cofferdam	<input type="checkbox"/>	<input type="checkbox"/>
Face mask	<input type="checkbox"/>	<input type="checkbox"/>	Face pillow	<input type="checkbox"/>	<input type="checkbox"/>	Garden hose	<input type="checkbox"/>	<input type="checkbox"/>
Ostomy bag	<input type="checkbox"/>	<input type="checkbox"/>	IV tubing	<input type="checkbox"/>	<input type="checkbox"/>	Rubber ball	<input type="checkbox"/>	<input type="checkbox"/>
Rubber band	<input type="checkbox"/>	<input type="checkbox"/>	Rubber cement	<input type="checkbox"/>	<input type="checkbox"/>	Rubber gloves	<input type="checkbox"/>	<input type="checkbox"/>
Dish gloves	<input type="checkbox"/>	<input type="checkbox"/>	Golf/Tennis grip	<input type="checkbox"/>	<input type="checkbox"/>			

Other items that you have reacted to that you think contain latex: \_\_\_\_\_

37. Do you have personal history of any of the following?

	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Urticaria (itching)	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	Contact Dermatitis (rash)	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Rhinitis (runny nose)	<input type="checkbox"/>	<input type="checkbox"/>

38. Do you carry an epinephrine (EpiPen/AnaKit)? .....YES NO
- If yes, why? \_\_\_\_\_
39. Have you ever been told not to lift heavy objects? When?.....YES NO
40. Have you ever had a **back/neck injury/strain**? When?.....YES NO
41. Have you ever had **back or neck surgery**? When? .....YES NO
42. Do you have a physical condition that limits your activity or prevents you from performing certain body movements such as bending, lifting or squatting, pushing/pulling? .....YES NO

**Comments:**

**I hereby certify that information given on this questionnaire is true and accurate to the best of my knowledge. I understand that falsification of information may be reason for dismissal.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date