



UVA-WorkMed
545 Ray C. Hunt Drive
Fontaine Research Park
Fax - 434-243-0078

Section 1

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

Name \_\_\_\_\_ Birth Date: \_\_\_\_\_
Last First Middle/Maiden

In what country were you born? \_\_\_\_\_

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

Department Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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

In case of emergency please contact: \_\_\_\_\_ Phone \_\_\_\_\_
Name/Relationship

Section 2

Check if there is any family history of the following diseases:

- Checkboxes for Tuberculosis, High Blood Pressure, Cancer, Heart Disease, Kidney disease, Arthritis, Epilepsy, Diabetes

- 1. Do you take any medication regularly? If so, what? YES NO
2. Are you allergic to any medication or food? If so, what? YES NO
3. Do you have any type of chronic dermatitis? If so, what? YES NO
4. Have you ever had the tetanus series? Date Date of last booster
5. Do you wear corrective lenses? YES NO
6. Do you have any chronic eye conditions? YES NO
7. Do you have trouble identifying colors? YES NO
8. Do you have any loss of hearing? YES NO
9. Do you have a hearing aid? YES NO
10. Do you have hay fever? YES NO
11. Do you suffer from asthma? YES NO
12. Do you wheeze or have to gasp for breath? YES NO
13. Have you ever had a chronic chest condition (emphysema, bronchitis)? YES NO
14. Do you smoke cigarettes? How many a day? YES NO
15. Has a doctor ever said your blood pressure was too high? YES NO
16. Have you ever been bothered by a thumping or racing heart? YES NO



If yes, to what specifically did the physician say you were allergic? \_\_\_\_\_

54. 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: \_\_\_\_\_

55. 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"/>

56. Do you carry an epinephrine (EpiPen/AnaKit)? ..... YES NO

If yes, why? \_\_\_\_\_

57. Do you have any food allergies?..... YES NO

If yes, are you allergic to any of the following? Common symptoms are mouth tingling, lip swelling, itchy throat, rhinorrhea, wheezing, urticaria, or nausea.

- Avocado      Banana      Chestnut      Kiwi      Papaya  
Passion fruit      Peach      Raw potato      Tomato      Nuts \_\_\_\_\_

Other food allergies: \_\_\_\_\_

58. Have you ever had any adverse reactions or complications to any previous surgeries? ..... YES NO

59. How many **previous surgeries** have you had? \_\_\_\_\_

60. Have you had any **physical problems while having dental work completed**? \_\_\_\_\_

61. Do you have any congenital abnormalities (e.g. spina bifida)?..... YES NO

If yes, what type? \_\_\_\_\_

62. What is your occupation? \_\_\_\_\_

63. Did any of your post or present occupations involve frequent contact with latex products?..... YES NO

64. Have you ever had a reaction to a latex product? ..... YES NO

If yes, please explain what happened. \_\_\_\_\_

## Section 4

65. Do you have a hernia (rupture)? ..... YES NO

66. Have you ever had a surgical repair for a hernia? ..... YES NO

67. Are your joints often painfully swollen? .....YES NO
68. Do your muscles and joints feel stiff on arising?.....YES NO
69. Do you usually have pain in the arms and legs? .....YES NO
70. Do you have a diagnosis of arthritis, osteoarthritis or rheumatoid arthritis?.....YES NO
71. Do you have painful feet? .....YES NO
72. Are you ever stiff and sore after heavy work? .....YES NO
73. Have you ever been told not to lift heavy objects? When?.....YES NO
74. Have you ever had a **back/neck injury/strain**? When? .....YES NO
75. Have you ever had **back or neck surgery**? When? .....YES NO
76. Have you ever had a **back or neck injury** that required you to miss work, restrict activity, or require bed rest?.....YES NO
77. Do you have a **physical disability**? .....YES NO
78. Has any part of your body ever been paralyzed? When? \_\_\_\_\_ What part? \_\_\_\_\_ .....YES NO
79. Have you ever had knee surgery? When?.....YES NO
80. Do you have a physical condition that limits your activity or prevents you from performing certain body movements such as bending, lifting or squatting? .....YES NO
81. Do you have any conditions effecting the joints such as bursitis, dislocation, or other disabling joint diseases?.....YES NO
82. Do you regularly exercise (running, jogging, swimming, walking, bicycling, aerobics, etc.)?.....YES NO
83. Do you play any sport regularly (softball, tennis, basketball)? .....YES NO

**Comments:**

## Section 5

**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

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_