



UVA-WorkMed
P.O. Box 800357
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:

- o Tuberculosis o High Blood Pressure o Cancer o Heart Disease
o Kidney disease o Arthritis o Epilepsy o 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
17. Do you have trouble with dizziness or lightheadedness? YES NO

18. Do you ever get pains or tightness in your chest?..... YES NO
19. Do you often have difficulty in breathing? YES NO
20. Do you often have trouble with swollen feet or ankles? YES NO
21. Have you ever been told that you have a heart murmur, or any other heart condition? YES NO
22. Do you have trouble stopping even a small cut from bleeding? YES NO
23. Have you ever had a seizure or convulsion (**epilepsy**)? YES NO
24. Have you frequently had episodes of dizziness or fainting?..... YES NO
25. Do you have frequent **headaches**? YES NO
26. Has your vision ever been effected by headaches? YES NO
27. Do cuts in your skin usually stay open a long time? YES NO
28. Are you often bothered by severe itching?..... YES NO
29. Are you often troubled with boils?..... YES NO
30. Have you ever had any sensitivity to chemicals? YES NO
31. Have you ever had **Eczema**?..... YES NO
32. Have you ever felt you should cut down on your **drinking**?..... YES NO
33. Have people annoyed you by criticizing your drinking?..... YES NO
34. Have you ever felt bad or guilty about your drinking? YES NO
35. 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
36. Have you ever been hospitalized for any illness, injury or surgery? YES NO
37. Do you have any chronic illnesses? YES NO
- 38. Have you ever had chickenpox? YES NO Unknown**
39. Have you ever had a rubella titer (German Measles) drawn? When?..... YES NO
40. Have you ever had a measles, **mumps and/or rubella vaccine**? When? YES NO
41. Have you ever had a **reaction (redness and swelling) to a tuberculin skin test**? YES NO
42. Have you ever coughed up blood? YES NO
43. Do you sometimes have severe soaking sweats a night?..... YES NO
44. Have you ever had **tuberculosis**? When? YES NO
45. Did you ever live with anyone who had tuberculosis? When? YES NO
46. Have you ever received the **hepatitis B vaccination**? When?..... YES NO
47. Do you frequently have **diarrhea**? YES NO
48. Have you ever had **yellow jaundice/hepatitis**? When?..... YES NO
49. Have you ever been told that you have a **chronic liver disease**? YES NO
50. Have you ever been hospitalized for mental illness or nervous breakdown? YES NO
51. Have you ever received psychiatric treatment or been advised by a doctor to have it?..... YES NO
52. Have you ever been addicted to or constantly used drugs?..... YES NO

Section 3

53. 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? _____
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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="radio"/>	<input type="radio"/>	Balloon	<input type="radio"/>	<input type="radio"/>	Bandage	<input type="radio"/>	<input type="radio"/>
Dental mask	<input type="radio"/>	<input type="radio"/>	Condom	<input type="radio"/>	<input type="radio"/>	Dental cofferdam	<input type="radio"/>	<input type="radio"/>
Face mask	<input type="radio"/>	<input type="radio"/>	Face pillow	<input type="radio"/>	<input type="radio"/>	Garden hose	<input type="radio"/>	<input type="radio"/>
Ostomy bag	<input type="radio"/>	<input type="radio"/>	IV tubing	<input type="radio"/>	<input type="radio"/>	Rubber ball	<input type="radio"/>	<input type="radio"/>
Rubber band	<input type="radio"/>	<input type="radio"/>	Rubber cement	<input type="radio"/>	<input type="radio"/>	Rubber gloves	<input type="radio"/>	<input type="radio"/>
Dish gloves	<input type="radio"/>	<input type="radio"/>	Golf/Tennis grip	<input type="radio"/>	<input type="radio"/>			

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="radio"/>	<input type="radio"/>	Urticaria (itching)	<input type="radio"/>	<input type="radio"/>
Conjunctivitis	<input type="radio"/>	<input type="radio"/>	Contact Dermatitis (rash)	<input type="radio"/>	<input type="radio"/>
Eczema	<input type="radio"/>	<input type="radio"/>	Rhinitis (runny nose)	<input type="radio"/>	<input type="radio"/>

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
84. Have you ever been told you stop breathing during sleep? (Circle one)
 (1) Never (2) Sometimes (<3 nights a week) (3) Often (3-7 nights a week) (4) Uncertain
85. How often do you snore? (Circle one)
 (1) Never (2) Moderate (<3 nights a week) (3) Most nights (3-7 nights a week) (4) Uncertain

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: _____