UTHealth
North Campus Tyler

Patient Name_____
MRN _____

Confidentiality Statement: This form requests that you provide personal health information that is protected by The University of Texas at Tyler (UTT) policy and State and Federal law. Your rights to the confidentiality of your personal health information will be strictly maintained by the UTT. Your information will be used or disclosed in accordance with those policies and laws only to the minimal extent necessary for your treatment or business operations.

Medical History

Type of exam: ☐ Pre-placement ☐ Transfer ☐ Periodic
☐ Return to Work ☐ Disability ☐ Worker's Compensation
☐ Other ☐ Health Promotion/Baseline

Applicant/Employee

Name _____

Address _____ Date of Birth _____
_____

Sex: ☐ Male ☐ Female

Telephone: _____ Job _____

Department: _____ Supr _____ Phone _____

Company _____

Who should be contacted in case of emergency?

Name _____ Relationship _____

Address _____ Telephone (hm) _____

(wk) _____

Private physician's name _____ Specialty _____
_____

Address _____ Telephone _____
_____

*The university (UTT) provides the Occupational Health Program (OHP) for all individuals working with animals, and those with potential exposure to certain biological, chemical, and other hazards. The OHP is accomplished by assessment, management, education, and preventive medicine. The medical surveillance is a critical component of the OHP. I understand that this Health Assessment provides a baseline health assessment that can assist the Health Care Provider (HCP) in offering targeted health risk counseling and/or referral to me. I also understand that I may be contacted by the HCP to clarify my response, or lack of response, to certain questions asked in this section.
_____ By initialing here, I understand the information as stated above.

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A) Medical History (Please check all that apply).
Do you have, or have you ever had:

_____ allergies (list here)
_____
_____
_____ liver disease (hepatitis) jaundice
_____ night sweats or fever
_____ recent weight loss/gain
_____ convulsions or fits
_____ memory loss
_____ numbness/tingling
_____ fainting/dizzy spells
_____ headaches
_____ paralysis
_____ stroke/blood clot
_____ wear eyeglasses
_____ reading

_____distance
_____ contact lenses
_____ color blindness
_____ cataracts
_____ glaucoma
_____ vision problems
_____ hearing problems
_____ noise in ears
_____ balance problems
_____ sinus problems
_____ mouth sores
_____ change in voice
_____ hoarseness
_____ difficulty swallowing
_____ skin diseases (list here)
_____
_____
_____ stress
_____ depression
_____ prior drug/alcohol treatment
_____ lung trouble
_____ hay fever
_____ asthma
_____ bronchitis
_____ pneumonia
_____ operations (list date & type)
_____
_____
_____
_____
_____

_____ Chest pain
_____ rheumatic fever
_____ irregular heart beat
_____ heart murmur
_____ high blood pressure
_____ swollen ankles
_____ varicose veins
_____ shortness of breath
_____ ulcers
_____ change in bowel or bladder habits
_____ hernia
_____ nausea/vomiting
_____ blood in urine
_____ kidney problems
_____ reproductive problems

_____ bladder or reproductive infections
_____ back injury
_____ joint injury/pain
_____ arthritis
_____ broken bones
_____ blood disease
_____ bleed easily
_____ anemia
_____ diabetes
_____ thyroid problems
_____ cancer
_____ change in any wart or mole
_____ chew/dip tobacco
_____ average alcohol intake: _____
_____ per day
_____ per week
_____ trouble sleeping

_____ tuberculosis
_____ persistent cough
_____ cough up blood
_____ smoked
_____ # yrs
_____cigarettes # ____ pks/day
_____ cigars # _____ day

_____ pipe # bowls _____day
_____ still smoking?
_____ quit? Date: _____
_____ exposed to second hand smoke?
_____ work _____ home

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B) Medications (list any used on a regular basis. Include birth control medications and nonprescription drugs such as vitamins, cold remedies, aspiring, etc. If none, so state).

_____
_____
_____

C) Do you use any prostheses, colostomy appliances, artificial limbs, braces, etc.?

☐ No ☐ Yes, please explain

_____
_____

D) ANIMAL INFORMATION (Identify animals you will be working with)
[ ] Amphibians; [ ] Birds; [ ] Rabbits; [ ] Reptiles; [ ] Laboratory Rodents (rats, mice, guinea pigs, hamsters, etc.);
[ ] Other (specify) _____

E) ANIMAL ALLERGIES

Yes	No	Description
[ ]	[ ]	Do you have a personal or family history of allergies (sneezing, runny or stuffy nose, watery or itchy eyes, coughing, wheezing, shortness of breath, chest tightness, skin rash or hives derived from exposure to mold, pollen, dust mites, latex, or other contaminants? If yes, indicate the source of the allergies.
[ ]	[ ]	Have these symptoms required any treatment with over-the-counter medications (Claritin, Benadryl, decongestants, eye drops, etc.) or necessitated treatment by your own physician?
[ ]	[ ]	Have you experienced allergies (sneezing, runny or stuffy nose, watery or itchy eyes, coughing, wheezing, shortness of breath, chest tightness, skin rash or hives after exposure to animals or their cages and bedding? If yes, indicate what type of animal(s).
[ ]	[ ]	Do you have a personal or family history of asthma, asthma-like symptoms, hay fever or eczema? If yes, indicate. What is the cause?
[ ]	[ ]	Have you had to wear a respirator, goggles or protective clothing to protect yourself from allergies (e.g., hay fever [rhinitis], eye symptoms, hives or asthma) at work?

F) OTHER

Yes	No	Description
[ ]	[ ]	Have you ever been evaluated for a lab animal or research related health problem? If yes, please explain.
[ ]	[ ]	Are you immunosuppressed, post-splenectomy or taking immunosuppressant drugs? Do you have an immune suppressing condition? This can occur due to an immunodeficiency disorder/disease, taking medications that suppress the immune system such as long term corticosteroid use or undergoing surgery such as an organ transplant or spleen removal. If yes, indicate the condition.

G) Do you have any hobbies? ☐ No ☐ Yes, please explain

_____
_____

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H) Work History (list in chronological order each job, including military service. Please list all jobs):

Date from:	To:	Position/Job duties	Company

1) Have you ever received medical surveillance (periodic check-ups or tests) as part of a prior job?
☐ No ☐ Yes If yes, list results: _____

2) Have you ever been hurt or injured in previous jobs? ☐ No ☐ Yes If yes, explain:
_____
_____

Last tetanus shot: _____
_____
_____
_____
_____
_____

Comment Section:

Female Personnel: If you are pregnant or become pregnant while involved in the animal care and use program, certain precautions may need to be taken during your pregnancy due to the risks associated with animals, biohazardous materials, radiation, or chemical agents. You are encouraged to discuss this with your personal care physician. Female personnel planning a pregnancy or who become pregnant while working with lab animals or in a laboratory setting are NOT required to notify the institution of this information. However, OHP is available to confidentially discuss any reproductive health concerns you have involving your work with lab animals and/or laboratory work.

Applicant/Employee: I certify that the above information is true and correct to the best of my knowledge.
Signature:_____ Date: _____

Reviewed by: _____
Signature Nurse/Physician Date

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