Occupational Health
Pre-Placement Health Evaluation

ECU HEALTH

_____ **Vidant Bertie**
_____ **Vidant RCH**
_____ **Vidant Edgecombe**
_____ **Vidant Chowan**
_____ **Vidant Duplin**
_____ **Vidant OH Clinic**
_____ **The Outer Banks Hosp.**
_____ **Vidant Beaufort**
_____ **Vidant North**

Social Security #: _____- _____- _____ Employment Date: _____/_____/_____
Orientation

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Name: _____
Last First Middle

Address: _____
Street./Apt./Box City State Zip Home Phone# & Cell Phone#

_____ _____ ☐Part Time _____
Department Position ☐Full Time Manager

_____
Personal Physician's Name and Address

_____
Name of Emergency Contact Relationship Phone #

Personal Health History

ALLERGIES: (Medication – Food – Latex – Etc.) _____

1. Have you ever had a **positive** TB skin test? ☐ **YES** ☐ **NO if** yes, when & what medication taken for how long: ____

_____

2 Have you ever had surgery or been a patient in a hospital in the past 10 years? ☐ **YES** ☐ **NO if** yes, please list:

_____

_____

3. Are you receiving any medical treatment at the present time? ☐ **YES** ☐ **NO** if yes, give reason and physician's name:

_____

_____

4. Have you ever been turned down for military service, life insurance, or employment for health reasons? ☐ **YES** ☐ **NO** if yes, explain: _____

5. Have you ever-received benefits and/or a permanent impairment rating as a result of a job related injury or illness? ☐ **YES** ☐ **NO** if yes, explain: _____

_____

6. Have you lost any time from work for illness or injury during the past 5 years? ☐ **YES** ☐ **NO if** yes, explain: _____

_____

7. Have you ever had any work or activity restrictions due to your health? ☐ **YES** ☐ **NO if** yes, explain: _____

_____

8. Have you ever been injured in a motor vehicle accident? ☐ **YES** ☐ **NO** if yes, explain: _____

_____

This Section to be completed by OH Nurse

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CONFIDENTIAL

Have you **EVER BEEN TREATED** for problems related to any of the following:
(Check "YES" or "NO" to each)

YES	NO	CONDITION	YES	NO	CONDITION
☐	☐	1. Alcohol Dependence	☐	☐	24. Hernia (Rupture)
☐	☐	2. Allergies (Food, Environmental)	☐	☐	25. Hypertension
☐	☐	3. Anxiety/Depression/Nervous Breakdown	☐	☐	26. Jaundice
☐	☐	4. Arthritis	☐	☐	27. Joints (elbows/shoulder/wrist/knee pain)
☐	☐	5. Asthma, Bronchitis, Emphysema	☐	☐	28. Latex Allergy/Reaction
☐	☐	6. Back/Spine/Neck (Strains, fractures)	☐	☐	29. Lung/Respiratory
☐	☐	7. Bone (fractures)	☐	☐	30. Lupus
☐	☐	8. Brain/Head	☐	☐	31. MI/Heart Attack
☐	☐	9. Bursitis	☐	☐	32. Muscle Strains/Sprains
☐	☐	10. Cancer	☐	☐	33. Neuro/Muscular Condition
☐	☐	11. Carpal Tunnel Syndrome	☐	☐	34. Organ Transplant
☐	☐	12. Chronic Coughing	☐	☐	35. Painful/Flat feet/heel
☐	☐	13. Coughing up Blood	☐	☐	36. Rheumatism
☐	☐	14. Currently/possibly Pregnant	☐	☐	37. Seizures/Fits/Convulsions
☐	☐	14. Deafness/Hearing Difficulty	☐	☐	38. Shortness of Breath
☐	☐	15. Diabetes (Sugar in Blood/Urine)	☐	☐	39. Sickle Cell Anemia
☐	☐	16. Dizziness	☐	☐	40. Skin (Rash, Dermatitis, Other)
☐	☐	17. Drug Abuse (Prescription/Other)	☐	☐	41. Stroke
☐	☐	18. Eye-Infection/Disease/Vision	☐	☐	42.Swollen Ankles
☐	☐	19. Fainting Spells	☐	☐	43. Tendonitis
☐	☐	20. Frequent Headaches/Migraines	☐	☐	44. Tuberculosis (TB)
☐	☐	21. GI Disorder/Disease	☐	☐	45. Other Disorder/Disease
☐	☐	22. Heart/Coronary Disease	☐	☐	46. Renal Disease
☐	☐	23. Hepatitis	☐	☐	

YES	NO	
☐	☐	47. Do you have any physical, mental, or emotional condition, which could impact your ability to perform the job for which you were hired?
☐	☐	48. Do you require any accommodation or special consideration for any condition?
☐	☐	49. Do you currently have any of the following symptoms? Check ALL that apply: ☐ Unexplained Weight Loss ☐ Productive Cough ☐ Fever ☐ Infections ☐ Weakness ☐ Change in Appetite
☐	☐	50. Do you have any condition (illness, infection, or medication), which affects your immune system, making you more susceptible to infection?

State number and details of illnesses, injuries, or other health problems marked **"YES"**:

_____

_____

_____

_____

This Section to be completed by OH Nurse

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Do you: (Check YES or NO)

Smoke or Use Tobacco?	☐ YES ☐ NO	How much? _____
Drink Alcohol?	☐ YES ☐ NO	How much? _____
Drink Coffee/Caffeinated Drinks?	☐ YES ☐ NO	How much? _____
Take **ANY** Medication?	☐ YES ☐ NO	Please list all medications you have taken in the last 2 weeks: ____

_____

_____

_____

"*Reasonable accommodations may be provided for individuals with disabilities to the extent they do not impose an undue hardship. Such requests will be reviewed on a case-by-case basis and may require supporting documentation*."

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individuals' or family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services".

I understand and acknowledge that ECU Health relies on the truth of the information that I have provided herein as a basis for my continued employment and that falsification of any of the information I have provided shall be grounds for my immediate dismissal. To that end, I certify that the information I have given herein is true and complete and that I have been given an opportunity to ask any questions I might have about the information requested. I understand that my employment is conditioned upon my separate written authorization to disclose the health information provided by me, the results of this post-offer, pre-placement health examination and ongoing health information during the course of my employment to the management of ECU Health for the purposes of evaluating my fitness for employment and for other reasons deemed by management as necessary for the protection of health or safety purposes management to be necessary for health and safety purposes.

_____ _____

Signature of Conditional Employee ***Date***