Mount Sinai

ANNUAL HEALTH ASSESSMENT

PLEASE PRINT ALL INFORMATION IN BLACK INK (NO PENCIL) CLEARLY AND LEGIBLY

DATE:_____

EMPLOYEE # OR LAST 4 DIGITS OF SS #: _____ DATE OF BIRTH: _____
LAST NAME: _____ FIRST: _____ MID INIT: _____
SEX: ☐ MALE ☐ FEMALE
HOME ADDRESS/Street: _____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE/ Home: (___) _____ Other: (___) _____ Email Address: _____

NOTIFY IN CASE OF EMERGENCY
NAME: _____
ADDRESS: _____
TELEPHONE: _____

PERSONAL PHYSICIAN
NAME: _____
ADDRESS: _____
TELEPHONE: _____

EMPLOYER/COMPANY: _____
JOB TITLE: _____
SUPERVISOR'S NAME: _____

DEPARTMENT:
WORK UNIT LOCATION:
SHIFT: ☐ DAYS ☐ EVENINGS ☐ NIGHTS

A. ANNUAL HEALTH ASSESSMENT STATEMENT OF PURPOSE

This Annual Health Assessment is required by the New York State Department of Health, which requires assessment of the health status of all personnel, to assure that personnel are free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of duties. Accordingly this assessment is done for the purpose of determining limitations on your ability to perform your job, whether your job might present a possible risk to you or whether you might present a possible risk to patients or co-workers. IT IS NOT TO BE CONSIDERED AS A SUBSTITUTE FOR YOUR COMPLETE PHYSICAL/ REGULAR MEDICAL CARE BY YOUR PERSONAL PHYSICIAN.

BY SIGNING BELOW YOU REPRESENT THAT YOU HAVE READ THIS FORM AND BEEN GIVEN THE OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED AND THAT ALL ANSWERS AND STATEMENTS PROVIDED BY YOU ON THIS ASSESSMENT FORM ARE COMPLETE AND TRUE. YOU UNDERSTAND THAT YOUR EMPLOYMENT DEPENDS UPON FULL DISCLOSURE OF ALL NECESSARY JOB RELATED MEDICAL INFORMATION SOUGHT HEREIN AND THAT FALSE OR MISLEADING STATEMENTS COULD LEAD TO DISCIPLINE, UP TO AND INCLUDING YOUR IMMEDIATE DISMISSAL.

B. PRIVACY AND ACCESS TO MEDICAL RECORDS:

The relationship between you and Employee Health/ Occupational Medicine (EHS/OM) is confidential. Medical information will only be released when and if prescribed by law and/or at the written request of the employee. EHS/OM strictly observes this and all rules of medical ethics. Please note that if necessary, EHS/OM will communicate to your supervisor, and/or Human Resources at the Mount Sinai Health System facilities about your ability to mentally and physically perform essential job functions with or without restrictions or accommodations and without any threat of harm to yourself or to others. This is done strictly on a need to know basis.

Under the Occupational Safety & Health Act (OSHA Standard 1910.20) employees have the right to see their Employee health medical records and exposure records maintained by their employer, if any, related to potentially toxic substances or potentially harmful biological or physical agents. Forms are available in EHS/OM for the release of medical information, along with instructions on how the information requested can be secured.

SIGNATURE OF EMPLOYEE: _____ DATE: _____

EMPLOYEE NAME: _____ EMPLOYEE#/ LAST 4 DIGITS OF SS#: _____

PART I. ANNUAL HEALTH ASSESSMENT QUESTIONNAIRE

For EHS Use
☐ Clinical Contact
☐ No Clinical Contact

1. Has your job/position changed since your last Annual Health Assessment ☐ YES ☐ NO
   If yes, list all jobs/positions you have held since your last Annual Health Assessment:
   a. _____ b. _____ c._____

2. When did you last receive an influenza vaccination? (Influenza vaccination occurs from October – March each year)
   Date: (mm/yy)_____ Received at: ☐ EHS ☐ Primary MD/Pharmacy/Other_____
   ☐ I declined flu vaccine last season. ☐ I decline flu vaccine at present time.

3. Since your last Annual Health Assessment, have you been vaccinated for Hepatitis B, Varicella, Tdap (Tetanus, Diphtheria, Pertussis)
   And/or MMR (Measles, Mumps, Rubella)
   If yes, please provide vaccination dates. _____

4. Since your last exam, have you had or do you currently have any:

	yes	no	unsure	new	have now	under medical care
Contagious infectious disease	☐	☐	☐	☐	☐	☐
Rash	☐	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐	☐
Open sores or dermatitis	☐	☐	☐	☐	☐	☐
Enlarged lymph nodes	☐	☐	☐	☐	☐	☐
Fainting spells, dizziness, unexplained loss of consciousness	☐	☐	☐	☐	☐	☐

5. Since your last Annual Health Assessment, have you had or developed any other health impairment that could impose a potential risk to patients or co-workers or that may interfere with the performance of your job duties? ☐YES ☐NO
   If you have answered yes:
   a. Will you need any accommodations to do the essential functions of your current job? ☐ YES ☐ NO
   b. Please explain:

   _____

   _____

6. Since your last Annual Health Assessment, have you developed an addiction or habituation to alcohol, drugs or any other behavior altering substance that may interfere with the performance of your job duties or that poses a potential risk to patients or co-workers? ☐ YES ☐ NO
   If you have answered "yes" please explain below and report to Employee Health Services for further evaluation.

7. In your current job, do you directly handle, transport or work in close proximity to animals? ☐ YES ☐NO

8. In your job, have you had any exposure to any substances, gases or agents that you would like to discuss? ☐ YES ☐ NO
   If so please list: _____

9. Do you have any allergies to rubber gloves or latex? ☐YES ☐ NO
   Do you have any known allergy to substances used regularly in the performance of your job duties? ☐ YES ☐ NO

11. Only for employees with direct patient contact responsibilities or at risk for occupational exposure to blood or other potentially infectious materials.

Have you had a blood test which shows that you are immune to Hepatitis B? ☐ Yes ☐ No

If you have not received a complete immunization series for the Hepatitis B and have not been documented to be immune, you may request this vaccine at Employee Health Service free of charge.

If you elect not be immunized for Hepatitis B, you must complete a Declination Form which will be kept on file in your medical record. If, at a future date you wish to receive the Hepatitis B Vaccination series, this declination can be withdrawn.

- ☐ Previously Vaccinated with Hepatitis B
- ☐ Will accept Hepatitis B Vaccination
- ☐ Declines Hepatitis B Vaccine

12. Would you like confidential counseling for job related stress?____ Y____ N
13. Would you like information to help you stop smoking?____ Y____ N

continue on next page

EMPLOYEE NAME: _____ EMPLOYEE#/ LAST 4 DIGITS OF SS#: _____

PART II. TUBERCULOSIS SCREENING: RESPIRATOR CLEARANCE QUESTIONNAIRE

History of positive PPD ☐ YES ☐ NO ☐ UNSURE

History of positive Quantiferon ☐ YES ☐ NO ☐ UNSURE

Completed course of TB Prophylaxis or Treatment ☐ YES ☐ NO ☐ UNSURE

Date of last Chest X-Ray ☐ _____ ☐ UNKNOWN

TB SYMPTOM REVIEW QUESTIONARE:

Please check off any of the following you have experienced in the past twelve months. If there are several choices, check the one(s) which applies to you:

	yes	no	unsure	new	have now	under medical care
Persistent fevers	☐	☐	☐	☐	☐	☐
Frequent coughing with or w/o phlegm (circle which)	☐	☐	☐	☐	☐	☐
Coughed up blood	☐	☐	☐	☐	☐	☐
Night Sweats	☐	☐	☐	☐	☐	☐
Unplanned weight loss	☐	☐	☐	☐	☐	☐
Enlarged nodes	☐	☐	☐	☐	☐	☐

PART III. RESPIRATOR MEDICAL CLEARANCE (IF APPLICABLE)

Only complete this section if you have previously been fitted for a respirator (a device to prevent breathing of fumes/ biological agents) - **N95 or other, or if your job involves exposure to fumes/ biological agents.**

1. Since your last Annual Health Assessment:
   a. Were you advised/ required to wear a respirator? ☐ YES ☐ NO
      If yes, please describe the type of respirator worn: _____
   b. If used previously, have you had difficulty wearing a respirator? ☐ YES ☐ NO ☐ Not Used Previously
      If yes, please describe those difficulties: _____
   c. Do you have any fear of tight or enclosed spaces? ☐ YES ☐ NO

2. Since your last Annual Health Assessment have you had any of the following:
   Facial reconstructive or cosmetic surgery? ☐ YES ☐ NO
   Significant dental work (e.g. new dentures) ☐ YES ☐ NO
   Facial scars, burns or deformity? ☐ YES ☐ NO
   If yes, explain here:
   _____

3. Have you been told by your physician that you have chronic bronchitis, emphysema or any other chest disease? ☐ YES ☐ NO

4. Have you been told by your physician that you have angina or other serious heart disease (NOT including high blood pressure)? ☐ **YES** ☐ **NO**
   If yes, have you experienced this in the past six months? ☐ **YES** ☐ **NO**
   If yes, do you take medication for it? ☐ **YES** ☐ **NO**
   Have you had chest pains in the past three months? ☐ **YES** ☐ **NO**

5. **Have you been told by a physician that you have an abnormal heart beat or rhythm?** ☐ **YES** ☐ **NO**

6. **Would you like to speak to a clinician to discuss any of the above questions?** ☐ **YES** ☐ **NO**

continue on next page

FOR EMPLOYEE HEALTH USE ONLY – DO NOT WRITE IN THIS AREA

VITAL SIGNS: BP_____/_____ P_____ R_____ HT_____ WT_____

PPD DATE PLANTED:_____ R / L LOT #_____ EXP DATE_____ SIGNED _____

DATE READ_____ NEGATIVE _____ POSITIVE_____ MM INDURATION _____ SIGNED _____

QFT DATE:_____ RESULT:_____ SIGNED: _____

IF PPD / QFT POSITIVE - CXR RESULT: DATE_____ NEGATIVE____ POSITIVE____

Prior history of positive PPD or positive QFT ☐ YES ☐ NO
history of successful TB Prophylaxis ☐ YES ☐ NO

RESPIRATORY EVALUATION:
- ☐ Not applicable to this employee
- ☐ No restrictions on respirator use
- ☐ Some specific use restrictions
- ☐ No respirator use permitted
- ☐ Needs medical interview before clearance for respirator use

TB SCREENING FOLLOW UP
- ☐ Provider exam and counseling Date: _____ Signed: _____
- ☐ INH prophylaxis advised/risks and benefits discussed Date:_____ Signed: _____
- ☐ Consented/declined INH prophylaxis Date: _____ Signed: _____

☐ Fit Testing completed on _____
for _____ respirator
Signed: _____

ANNUAL HEALTH ASSESSMENT REVIEWER RECOMMENDATIONS:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ Return for annual TB testing and Fit testing by _____ date

_____ _____
(Legible Signature) Licensed Healthcare Provider Date / Time