MEDICAL HISTORY QUESTIONNAIRE

Full Name:	**DOB:**	☐ **M** ☐ **F**
SS#:	**Phone Number:**	
Address:	**City, State, Zip Code:**	
Position/Department:	**Campus Site:**	

PERSONAL HEALTH HISTORY

LATEX ALLERGY: ☐ **YES** ☐ **NO** **If yes, type of reaction:**

First Occurrence: **Under Treatment:**

ALLERGIES TO MEDICATIONS OR OTHER AGENTS	**TYPE OF REACTION**

CURRENT MEDICATIONS (prescriptions, over the counter, supplements) ☐ **None**

Name	Strength	Frequency	Prescription Number	Pharmacy Number
1.				
2.				
3.				
4.				
5.				

HOSPITALIZATIONS / SURGERIES ☐ **None**

Year	Reason	Year	Reason

Have you ever had any of the following OR received medical treatment for? (Check all that apply) ☐ **None**

☐ Heart Attack	☐ Asthma	☐ Anxiety	☐ Hepatitis
☐ Stroke	☐ Epilepsy	☐ Depression	☐ Rubella (German)
☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Measles (Red)
☐ Kidney Disease	☐ Bleeding Disorder	☐ Multiple Sclerosis	☐ Chickenpox
☐ Emphysema	☐ Angina / Chest Pain	☐ Mumps	☐ HIV / AIDS
☐ Alcohol or Drug Dependency / Abuse		☐ Tuberculosis	

List any other medical condition not listed above:

Have you ever had an injury to any of the following body part(s)? (Check all that apply)

☐ Back	☐ Shoulder	☐ Knee
☐ Wrist	☐ Hand / Finger	☐ Neck
☐ Ankle	☐ Head	☐ Hip
☐ Other (specify):		

Please provide date / details of each injury:

MEDICAL HISTORY QUESTIONNAIRE

TOBACCO HISTORY	
Do you currently smoke?	☐ Yes ☐ No
	If yes, how many packs per day?
	How many years have you been smoking?
Have you ever smoked in the past?	☐ Yes ☐ No
	If yes, how many packs per day?
	When did you quit?
Do you use other forms of tobacco:	
Vaping?	☐ Yes ☐ No
	If yes, how many times per day?
Pipes?	☐ Yes ☐ No
	If yes, how many times per day?
Cigars?	☐ Yes ☐ No
	If yes, how many times per day?
Chewing tobacco?	☐ Yes ☐ No
	If yes, how many times per day?

IMMUNIZATION HISTORY

Your immunization history is an important part of your total health and is important to protect the patients we serve. You are required to submit a full copy of your immunization records to the following:

1) Bring your copy to your visit with Employee Health,
2) Email copy to iwork@memorialhermann.org

If you do not have a copy of your immunization records, please indicate so here: ☐

Required Immunizations For Health Care Personnel

Hepatitis B	Varicella	Tetanus / Diptheria / Pertussis
MMR (Measles, Mumps, Rubella)	Meningitis	Influenza

Are you aware if you have had a non-response to a vaccine? ☐ Yes ☐ No
If yes, please provide which vaccine:

Are you currently registered with the state of Texas immunization database (ImmTrac)? ☐ Yes ☐ No

ALLERGIES

☐ Eggs	☐ 2-Phenoxyethanal	☐ Aluminum Hydroxide	☐ Amphotericin-B
☐ Yeast	☐ Mercury / Thimerosal	☐ Penicillin	☐ Polymyxin
☐ Gelatin	☐ Neomycin or Streptomycin	☐ Sulfa	☐ None
☐ Bee stings or history of Hives or Urticarial		☐ Beef protein, soy, lactose, phenol, casein, or formaldehyde	

Other allergies not listed above:

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MEDICAL HISTORY QUESTIONNAIRE

Have you… ever fainted from having injection or blood drawn?	☐ Yes ☐ No
ever had a fever after receiving a vaccination?	☐ Yes ☐ No
ever had any other bad reaction or side effect from a vaccination?	☐ Yes ☐ No
If yes, which vaccination?	
Do you… have an immune disorder, such as AIDS, Leukemia, or Cancer?	☐ Yes ☐ No
have close contact with anyone having an immune disorder? (Leukemia, Cancer, HIV)	☐ Yes ☐ No
have a family history of immunodeficiency?	☐ Yes ☐ No
Have you received a blood transfusion/blood products/immune globulin in the past 12 months?	☐ Yes ☐ No
Are you pregnant or planning pregnancy within 3 months?	☐ Yes ☐ No

TUBERCULOSIS
1. Have you ever had a positive tuberculosis test? ☐ Yes ☐ No If yes, when and what kind of test was it (e.g. positive TB blood test or positive TB skin test)?
2. Did you receive treatment? ☐ Yes ☐ No What kind of treatment and for how long?
3. Were you a ***resident of*** or have you ***ever been*** to any country **OTHER THAN** the United States, Canada, Australia, New Zealand and those in Northern Europe or Western Europe? ☐ Yes ☐ No If yes, when and for how long?
4. Have you been in close, prolonged contact with an individual or family member who was diagnosed with infectious TB? ☐ Yes ☐ No
5. Have you been involved in a known/confirmed job-related exposure to TB? ☐ Yes ☐ No

I certify that the statements on this form are true and complete to the best of my knowledge. I understand that any misstatement or omission on this medical history questionnaire is cause for termination of my employment. Should I be referred to a Physician for further consultation I understand my employment offer will be suspended pending final results and expenses are my responsibility.

_____

Signature

PLEASE DO NOT WRITE BELOW THIS LINE.

EMPLOYEE HEALTH NOTES:

Reviewed by:_____ Date:_____

NOTICE OF NO WORKERS' COMPENSATION INSURANCE COVERAGE

COVERAGE: **Memorial Hermann Health System, Memorial Hermann Hospital System, MHMG, MHMD, Memorial Hermann Health Insurance, Memorial Hermann Employer Solutions, Memorial Hermann Health Ventures, Inc., MH Physicians of Texas, and Memorial Hermann Community Benefit Corporation** have elected not to obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Texas Department of Insurance, Division of Workers' Compensation has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Workers' Health & Safety at 1-800-452-9595.

COBERTURA: **Memorial Hermann Health System, Memorial Hermann Hospital System, MHMG, MHMD, Memorial Hermann Health Insurance, Memorial Hermann Employer Solutions, Memorial Hermann Health Ventures, Inc., MH Physicians of Texas, and Memorial Hermann Community Benefit Corporation** ha elegido no obtener cobertura de compensacion para trabajadores. Como empleado de un usted no es elegible para recibir beneficios de compensacion bajo la Ley de Compensacion para Trabajadores de Texas. Sin embargo, un empleador sin cobertura puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener informacion acerca de la disponibilidad de otros beneficios o compensacion por una lesion o enfermedad relacionada con el trabajo. Ademas, usted puede tener derechos bajo la ley de "Derecho Comun" de Texas, si usted ha sufrido una lesion o enfermedad relacionada con su trabajo. Es requerido que su empleador le proporcione informacion acerca de la cobertura, por escrito, cuando es contrado o cuando su empleador obtiene o deja de tener cobertura de seguros de compensacion para trabajadores.

LINEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS: Departmento De Seguros de Texas, Division De Coompensacion Para Trabajadores ha establecido una linea telefonica gratuita las 24 horas, para reporter condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohibe que los empleadores suspendan, despidan o discriminen contra un empleado o empleada porque el o ella, de Buena fe, reporta una presunta violacion ocupacional de salud o seguridad. Comuniquese con la Seccion de Seguridad y Salud al telefono 1-800-452-9595.

I have read and understand the above notice.

He leido y entiendo esta notificacion.

EMPLOYEE:
EMPLEADO:_____

EMPLOYER:
PATRON:_____

DATE:
FECHA:_____

EMPLOYEE DRUG TESTING CONSENT FORM

1. I understand that I am being asked to provide a specimen for testing to determine if I have used drugs. I UNDERSTAND THAT I DO NOT HAVE TO PROVIDE SUCH A SPECIMEN IF I CHOOSE NOT TO DO SO, BUT THAT MY REFUSAL MAY RESULT IN DISCIPLINARY ACTION INCLUDING IMMEDIATE DISCHARGE.

2. I hereby give consent to and authorize MHHS and its agents, servants, employees, and/or physicians chosen by MHHS to take a specimen and to use such specimen in any manner MHHS and its agents, servants, employees and physicians deem appropriate including, but not limited to, releasing such specimen to a testing laboratory, hospital, other person or service for testing. I hereby give consent to and authorize MHHS and its agents, servants, employees, and/or physicians chosen by MHHS and any such testing laboratory, hospital, person, or service to conduct drug tests or other information concerning the specimen to MHHS, or to any person or firm designated by MHHS. I hereby release MHHS, its officers, agents, employees and/or physicians chosen by MHHS from any and all claims or liability arising out of or relating to the enforcement of its Substance Abuse Policy, specifically including, but not limited to, all claims for injuries to my person, or damage to my reputation resulting from drug testing, or the release of information concerning such testing.

☐ I CONSENT TO PROVIDE A SPECIMEN FOR USE IN THE MANNER DESCRIBED HEREIN.

☐ I REFUSE TO PROVIDE A SPECIMEN.

_____ _____

Employee Signature **Date**

_____

Employee PRINT NAME

_____ _____

Witness Signature **Date**

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Employee Drug Testing Consent Form

APPLICANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Employment substance abuse screening is a key component of the MHHS applicant selection/employment process. The screening is for both drugs and alcohol. You are requested to list below any prescription or over the counter drugs which you are presently taking or have taken in the past 14 days. Include any kind of capsule, pill, or medication regardless of type. If the drug was prescribed by a physician, include the physician's name. If the drug screen reveals evidence of a drug you neglected to disclose, it could result in failure to qualify for employment. If you have taken no such drugs, please write "none" in the space below. If you fail the substance abuse screen, you may not reapply for employment within 1 year from the date of your drug and alcohol test.

During the employment screening process, information pertinent to the results of the drug screen will be communicated to Occupational Health, and as appropriate, other medical personnel.

CURRENT MEDICATIONS (prescriptions, over the counter, supplements) ☐ **None**

Name	Strength	Frequency	Prescription Number	Pharmacy Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				

I have carefully read the above explanation of MHHS's employment drug screening procedure. I authorize MHHS to contact my physician to confirm medical prescriptions. If necessary, I understand and agree that failure to pass the required exam, which includes a drug screen, will exclude me from further consideration of employment.

_____ _____

Applicant Signature **DATE**

_____

PRINT YOUR NAME CLEARLY