

Must complete ALL sections.

Post-Employment Screening Patient Contact Form UF Employee/Volunteer

The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job.

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.

Name:	Date of Birth:								
(Last, First, Middle Initial)					(Mm / dd /	['] yy)			
UF ID #:		Gender	at Birth:		Male		Female		
Email Address:	Cell number:								
Address:									
City, State Zip:									
Work Site: Gainesville	Jacksonv	Other:							
Department:	Super	visor/Pro	gram Dire	ector: _					
Position Number:	Job T	Job Title:							
Section I - Medical History									
Do you have now, have you ever had	d, or have you r	eceived tr	eatment for	the fol	llowing:				
	Yes	No	If YES		•		s needed to		
Alcohol abuse/alcoholism				e	xplain with	dates.			
Allergies to medications/foods									
Back or neck injury									
Carpal Tunnel syndrome									
Chronic back pain									
Current Medications: doses and									
Frequency									
Diabetes (type)									
Difficulty hearing/hearing									
aides Drug abuse/addiction									
Hospitalizations/Surgeries									
Immunosuppression Infectious									
Digagg	П	П							

Disease



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	Yes	No	If YES use as n	nany lines below	as neede	d to	
Latex allergy or other skin sensitivities				explain			
Other hand/wrist problems							
Other liver disease (type)							
Visual loss (one or both eyes)							
Have you ever had a work-related illness on If yes, explain:	• •	□ Yes	□ No				
Have you been cleared by a medica	•		•		Yes	_	No
Are you currently recovering from any sign If yes, explain:			•		No		
Have you been cleared by a medica	ıl provider	to return to fu	ll duty without re	strictions?	Yes		No
Do you have any medical or psychological performing the duties outlined in your job of If yes, explain:							
Would you like to speak to a UF Occupatio If yes, daytime phone:			bout any of the in:	formation you ha	ve given	above?	ı
Print Name:			U FID#:				
Signature:			Date:				



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Today's Date:												
Last Name:		ı			First N	Name:					MI:	
Phone:	Date of Birth:					Gende	r at Birth:		Male		Fe	emale
Job Title:					Heigh	t:	(ft)	(in)	Wei	ight:		(lbs)
Do you know how to contact the	Healthcare pr	ofessi	onal w	ho will	reviev	v this?		Yes			No	
Can you read English:								Yes			No	
Do you exercise:									No			
Have you worn a respirator in the past?								No				
Physical exertion while wearing	a respirator:							Yes			No	
Medical Questionnaire												
Do you <i>currently</i> smoke tobacco				n the la	st mo	nth?		Yes			No	
If "yes" to any of the following, I	now many pacl	ks per	day?									
How any years have you smoked	1 ?											
Have you ever had any of the fo	ollowing condition	tions?										
		YES	NO								YES	NO
Seizures (fits)				Claus	troph	obia (fea	ar of close	d-in place	s)			
Diabetes (sugar disease)				Trouk	ole sm	elling o	dors					
Allergic reaction that interfere w	ith your breat	hing										
If yes, please explain:												
Have you <i>ever had</i> any of the fo	ollowing pulmo	nary o	or lung	proble	ems?							
		YES	NO								YES	NO
Asbestosis				Pneu	motho	rax (coll	apsed lung)					
Asthma				Lung	Cance	r						
Chronic bronchitis				Broke	en ribs	;						
Emphysema				Any c	hest in	njuries c	r surgerie	es				
Pneumonia				Silico	sis							
Tuberculosis		□ □ Any other lung problem you've been told about										
Please explain ALL Yes answers:												
Do you <i>currently</i> have any of th	e following syr	mpton	ns of p	ulmona	ary or	lung illr	ness					
	<i>,</i>	YES	NO.		-	•					YES	NO
Shortness of breath				Short	ness c	of breath	n that inte	rferes witl	n your jo	ob		
Shortness of breath when walking	ng fast on							alking with				
level ground or walking up a slig	-							evel groun				
Shortness of breath when washi						-	•	n walking a		own		
dressing yourself	<u> </u>					-	el ground	_	•			
Coughing that produces phlegm	(thick sputum)			•		_	_	ly in the m	norning			
Coughing that occurs mostly wh							in the las		J6			
lying down	,			- 3 - 0		,						
Wheezing				Chest	pain	when yo	ou breathe	e deeply				
Wheezing that interferes with yo	our job					•	ry/lung sy					
Please explain ALL Yes answers:	-			•	•			-				



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Have you ever had any of the following cardiovascular or heart problems?								
	YES	NO		YES	NO			
Heart attack			Heart arrhythmia (heart beating irregularly)					
Stroke			High blood pressure					
Heart failure			Swelling in your legs not caused by walking					
			, , ,					
Please explain ALL Yes answers:								
Have you ever had any of the following cardio	ovascu	lar or l	neart symptoms:					
	YES	NO		YES	NO			
Frequent pain or tightness in your chest			Skipping/missing heartbeat (in last 2 years)					
Pain or tightness in your chest during			Heartburn-like symptoms not related to eating					
physical activity								
Pain or tightness in your chest that interferes			Any other symptoms that you think may be related					
with your job			to heart or circulation problems					
Please explain ALL Yes answers:								
Do you currently take medications for any of	the fol	lowing	;?					
	YES	NO		YES	NO			
Breathing or lung problems			Blood pressure					
Heart trouble			Seizure (fits)					
Please explain ALL Yes answers:			· ,					
•								
If you've used a respirator, have you ever had	d any o	f the f	ollowing problems while using a respirator?					
in you've used a respirator, have you ever had	YES	NO	onowing problems wrine using a respirator:	YES	NO			
Eye Irritation:			General weakness or fatigue:					
Skin allergies or rashes			Anxiety					
Any other problem that interferes with your use of a respirator If yes to any of above, please explain:								
h yes to any or above, please explain.								
Would you like to talk to the health care profe	csional	l who v	will review this questionnaire about your answers to					
Would you like to talk to the health care professional who will review this questionnaire about your answers to \Box this questionnaire?								
Additional comments:								
Additional comments.								
To the best of my knowledge, the information I have	e provi	ded is t	rue and accurate.					
Employee/Volunteer Signature:		Date		1				
OCCMED CLINIC USE ONLY								
TO BE COMPLETED BY EXAMINER/REVIEWER								
☐ The mandatory questionnaire has been review								
The Employee/Volunteer has been found to be physically able to use Single use, filter mask (four attachment points) N95 or PAPR.								
PAPR Only								
 There is insufficient information to make a determination at this time. This Employee/Volunteer has been found to be physically NOT able to use a respirator. 								
This Employee/Volunteer has been found to be physically NOT able to use a respirator.								
Reviewer's Name (print)		Revie	wer's Signature Date					



Post-Offer Screening Patient Contact Form

Name:		Date of Birth:	UF ID #	! :
	Required In	nmunizations		
Positive titer for immunity will so	abstitue for shot Mo/Day/Year	s on numbers 1 - Mo/Day/Year	4. Titers must ha Mo/Day/Year	ve labs attached.* Titer Date & Result*
1. Measles (2 doses after 1st birthday)	Wio, Bay, Tear	IVIO/ Bay/ Tear	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Their Bate a Nesait
2. Mumps (2 doses after 1st birthday)			111111111	
3. Rubella (2 doses after 1st birthday)			111111111	
4. Varicella (Chicken Pox; 2 doses)			111111111	
5. Hepatitis B (3 doses required)				Titer does not substitue
6. Tdap (adult booster within 10 years)		\\\\\\\		11111111111111
	•			
Re	quired Tuber	culosis Screen	ing	
months prior to start date. **TST's(PPE 28 days after a live virus immunizatio within 48 - 72 hours after placement.	n like measles, m CG is not a subst	numps, rubella, or itute for a previou	varicella. TST's(l us positive screeni	PPD's) should be read
, -	Date Placed	screening result t	nen see below.	Neg or Pos
PPD** #1 Skin Test (Tuberculosis Screening)				,
PPD** #2 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	ММ	Neg or Pos
Interferon-based Assay* (instead of PPD's		Result		
	(OR)	•	
If past positive PPD or positive Interfe a substitute for a previous positive screeni	ng for TB, 2) chest			
Doct positive DDD Chie Toet	Date Placed	Date Read	MM	Neg or Pos
Past positive PPD Skin Test		Date		Result
Interferon-based Assay* (attach	copy of lab)			
CXR* (only if past positive PPD)		Date		Result
*All titers, assays, a	nd chest X-	rays must h	ave results	attached
Official Office Stamp Here		Authorized Signatur	e	Date
An official stamp from a doctor's office clinic	or health denartm	ent AND an authorize	ed signature must an	near here or this form will

University of Florida
Occupational Medicine Program
Email: occmedclinic-riskassessment@ahc.ufl.edu

not be approved. You may not be the authorized signator of your own form.