HR Contact:

Jennifer Paradiso

**jenharab@hr.rutgers.edu**

Px Date: \_\_\_\_\_\_\_

Extension:

**Email:**

Time: \_\_\_\_\_\_\_\_\_\_

🞏 NB 🞏 Pisc.

 Employee Health Services

EOHSI Clinical Center Clinical Research Center

170 Frelinghuysen Road 1 Robert Wood Johnson Place, PO Box 19

Piscataway, New Jersey 08854 New Brunswick, New Jersey 08903-0019

Phone: (848) 445-0123 Phone: (732) 418-8466

Fax: (732) 445-0173 Fax: (732) 418-8126

 Confidential Employee Health Questionnaire

DATE \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

NAME (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

HOME ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip Code

HOME TELEPHONE NUMBER ( ) \_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

 area

DATE OF BIRTH \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ AGE \_\_\_\_\_\_ SEX 🞏 M 🞏 F

JOB TITLE : Unpaid Visiting Researcher Department: Office of Global Health

PATIENT CONTACT – Yes 🞏 NO

PERSON TO CONTACT IN EMERGENCY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE # ( ) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

 area

PRIMARY CARE PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TEL #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address to be used:

#319. 303 George Street, New Brunswick,

Phone: 848-932-0230,

Email: globalhealth@rwjms.rutgers.edu

Contact: Angela Gitau

HOW WOULD YOU DESCRIBE YOUR HEALTH? 🞏 Excellent 🞏 Good 🞏 Fair 🞏Poor

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL HEALTH HISTORY** | **NO** | **YES** | **PLEASE EXPLAIN ALL “YES”**  |
| Visited a physician in the past year?  |  |  |  |
| Absent from work or school for a medical reason in the past year? |  |  |  |
| Health worsened in the past year? |  |  |  |
| Ever absent from work or school for an illness or injury related to work or due to exposure to chemical or other hazards? |  |  |  |
| Wear prescription eyeglasses or contact lenses? |  |  |  |
| Any visual difficulties that are not correctable? |  |  |  |
| Use dentures? |  |  |  |
| Cold or sore throat more than twice a year? |  |  |  |
| Recurrent ear infections or perforated eardrum? |  |  |  |
| Difficulty hearing? |  |  |  |
| An abnormal hearing test ever? |  |  |  |
| Allergies to medicines, food, animals, or other substances in the environment? |  |  |  |
| Hayfever or other allergies? |  |  |  |
| Special diet for medical reasons? |  |  |  |
| Skin troubles? |  |  |  |
| Folliculitis or other skin rashes or diseases that would prevent you from shaving (for men) or interfere with wearing a respirator? |  |  |  |
| Any x-ray picture during the past year? |  |  |  |
| Date of last chest x-ray. |  |  |  |
| Prescription medications over the past month? |  |  |  |
| Any other medicines, including pills for colds, dieting, and headaches, vitamins, and eye and nose drops over the past month? |  |  |  |
| Hospital inpatient overnight? |  |  |  |
| Currently pregnant (for women)? |  |  |  |
| Served in military or uniformed services? |  |  |  |
| Any medical condition that requires you to restrict your activity? |  |  |  |
| Ever advised to change jobs or work assignments because of any health problem or injury? |  |  |  |
| Ever received compensation for any illness or injury resulting from work or military service? |  |  |  |
| Any other medical problems not mentioned above? |  |  |  |

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| **NONCOMMUNICABLE DISEASES HISTORY** | **NO** | **YES** | **PLEASE EXPLAIN ALL “YES” ANSWERS** |
| Chest pain when you exert yourself, for example, when climbing stairs or running? |  |  |  |
| Coronary artery disease or other heart disease? |  |  |  |
| Had a heart attack, coronary bypass surgery or any treatment for coronary artery disease? |  |  |  |
| Palpitations? |  |  |  |
| Rheumatic Fever? |  |  |  |
| Heart murmur? |  |  |  |
| More than borderline high blood pressure that is not being treated? |  |  |  |
| Blood pressure is greater than 150/90 with or without medications? |  |  |  |
| Quickly become short of breath when climbing stairs or running? |  |  |  |
| Asthma? |  |  |  |
| Chronic cough or other respiratory problems, for example, emphysema or bronchitis? |  |  |  |
| Any chronic lung disease? |  |  |  |
| An abnormal lung function test ever? |  |  |  |
| Frequent or persistent stomach or other intestinal trouble? |  |  |  |
| Hernia? |  |  |  |
| Back pain ever? |  |  |  |
| Broken bone or dislocation? |  |  |  |
| Painful, swollen, or still shoulder, arm, wrist, finger, leg, knee or foot? |  |  |  |
| Headaches that incapacitate you? |  |  |  |
| Paralyzed? |  |  |  |
| Fainted or unconscious? |  |  |  |
| Seizure disorder or epilepsy? |  |  |  |
| Claustrophobia? |  |  |  |
| Difficulty reading? |  |  |  |
| Learning disability? |  |  |  |
| Kidney or bladder trouble? |  |  |  |
| Blood in your urine? |  |  |  |
| Diabetes mellitus? |  |  |  |
| Weight change in the past year? |  |  |  |
| Treated for a cyst, growth, tumor, or cancer? |  |  |  |
| Amputation? |  |  |  |
| Any surgical operation? |  |  |  |
| Any other medical problems not mentioned above? |  |  |  |

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| **COMMUNICABLE DISEASES HISTORY** | **NO** | **YES** | **PLEASE EXPLAIN ALL “YES” ANSWERS** |
| Tuberculosis skin test (PPD) in the past 12 months? |  |  |  |
| Tuberculosis skin test (PPD) more than 12 months ago? |  |  |  |
| Positive or abnormal tuberculosis skin test ever? |  |  |  |
| Tuberculosis? |  |  |  |
| Told you need medicines for exposure to tuberculosis or for tuberculosis? |  |  |  |
| Immunized with the BCG (Bacille Calmette - Guerin) tuberculosis vaccine? |  |  |  |
| Lived or traveled outside the United States of Canada? |  |  |  |
| Close contact with a family member or other person who had tuberculosis? |  |  |  |
| Exposed to tuberculosis in a previous job? |  |  |  |
| Measles? |  |  |  |
| Immunized with the measles vaccine? |  |  |  |
| Rubella or German measles? |  |  |  |
| Immunized with the rubella vaccine? |  |  |  |
| Chicken pox or varicella? |  |  |  |
| Immunized with the chickenpox or varicella vaccine? |  |  |  |
| Mumps? |  |  |  |
| Immunized with Mumps vaccine? |  |  |  |
| Immunized for tetanus (tetanus shot) in the past 10 years? |  |  |  |
| Received a blood transfusion ever? |  |  |  |
| Exposed in a previous job to blood or body fluids that may have contained blood borne pathogens, including hepatitis B, hepatitis C, or human immunodeficiency virus?  |  |  |  |
| Hepatitis or jaundice? |  |  |  |
| Immunized with three doses of hepatitis vaccine? |  |  |  |
| Taken AZT? |  |  |  |
| Meningitis? |  |  |  |
| Told you need medicines for exposure to meningitis or for meningitis? |  |  |  |
| Immunized with meningitis vaccine? |  |  |  |
| Immunized with influenza vaccine? |  |  |  |

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| **OTHER EXPOSURES HISTORY** | **NO** | **YES** | **PLEASE EXPLAIN ALL “YES** |
| Smoke cigarettes currently? |  |  |  |
| Smoked cigarettes ever? |  |  |  |
| Used other tobacco products ever? |  |  |  |
| Drink alcohol, including beer, wine or other liquor? |  |  |  |
| If you drink any alcohol, ever attempted to cut down on your drinking? |  |  |  |
| If you drink any alcohol, ever been annoyed by other people criticizing your drinking? |  |  |  |
| If you drink any alcohol, ever felt guilty about drinking? |  |  |  |
| If you drink any alcohol, ever taken a morning eye-opener? |  |  |  |
| Used non-medical ( “recreational”) drugs? |  |  |  |
| Injured in a road traffic crash? |  |  |  |
| Injured in a fight or assault? |  |  |  |
| Hospitalized for an injury? |  |  |  |
| Worked with asbestos? |  |  |  |
| Worked with anesthetic gases, anti-cancer agents, ethylene oxide, formaldehyde, glutaraldehyde, or hazardous waste? |  |  |  |
| Worked with benzene, carbon tetrachloride, irritant dusts, isocyanates, paints, pesticides, petroleum products, phenol, silica, solvents, toluene, or welding fumes? |  |  |  |
| Worked with chromium, lead, mercury, or other metals? |  |  |  |
| Worked with radioactive materials or radiation-producing machines? |  |  |  |
| Exposed to loud noise for over one month? |  |  |  |
| Worked in a hospital or other healthcare facility? |  |  |  |
| Worked in building construction, mining, pipefitting, plumbing, a chemical plant, foundry, refinery or shipyard? |  |  |  |
| Exposed to chemical or other hazards not noted above? |  |  |  |
| Worked in other environments with materials that concern you? |  |  |  |
| Advised to wear protective equipment on any job? |  |  |  |
| Difficulty wearing medical (latex) gloves or other latex products? |  |  |  |
| Worn a respirator ever? |  |  |  |
| Been medically restricted from using a respirator? |  |  |  |
| Any symptoms from exposure to chemical or other hazards? |  |  |  |
| Any hobby activities that involve the use of or exposure to dusts, chemicals, or fumes? |  |  |  |
| Any other circumstances that should be reported to fairly complete the above questions and determine medical factors in your fitness for duty and job placement? |  |  |  |