HR Contact:_____
Extension: _____

Px Date: _____
Time: _____
☐ NB ☐ Pisc.

UMDNJ
ROBERT WOOD JOHNSON MEDICAL SCHOOL
University of Medicine & Dentistry of New Jersey

Employee Health Services

EOHSI Clinical Center
170 Frelinghuysen Road
Piscataway, New Jersey 08854
Phone: (732) 445-0123x600
Fax: (732) 445-0173

Clinical Research Center
1 Robert Wood Johnson Place, PO Box 19
New Brunswick, New Jersey 08903-0019
Phone: (732) 418-8466
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 _____DEPARTMENT_____

PATIENT CONTACT ☐ YES ☐ NO

PERSON TO CONTACT IN EMERGENCY _____ RELATIONSHIP_____

TELEPHONE # ( ) _____-_____
area

PRIMARY CARE PHYSICIAN _____CITY_____TEL #_____

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

	NO	YES	PLEASE EXPLAIN ALL "YES" ANSWERS
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?			

ADDITIONAL COMMENTS:

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?			

ADDITIONAL COMMENTS:

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?			

ADDITIONAL COMMENTS:

OTHER EXPOSURES HISTORY	NO	YES	PLEASE EXPLAIN ALL "YES" ANSWERS
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 expousre 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?			

I certify that the above is accurate and true to the best of my knowledge.

_____ _____/_____/_____

Signature **Date**