Single (F4-1)

Fold

Welcome to the Occupational Health Program of Allina.

Medical screening is a method to monitor the health of individuals that work in potentially hazardous environments. The purpose of this medical screening examination is to:

- Protect the worker from harmful exposures
- Assure the worker's ability to perform the job
- Fulfill governmental screening requirements

By considering the toxicity and degree of exposure workers have to various workplace agents (*both physical and chemical*), we have devised a testing protocol that is specific for your situation, and should help detect any adverse effects that may arise. For example, this might include liver tests for certain chemicals or chest x-rays for certain dusts. Since the results of these tests are important, we have taken precautions to ensure that the tests are accurate and valid.

The interpretation of these tests may differ from your own physician's interpretation. You generally go to your doctor when you have a specific problem and tests are done to see if you have a specific illness. On the other hand, we assume you are a healthy, normal individual and are looking for early changes in your health prior to becoming ill. Most medical tests were not designed for this purpose, so special expertise is needed for accurate interpretation.

The results that are known will be shared with you at the time of your exam. You will be informed of any abnormal results that are reported afterwards.

Please complete pages 1 - 5 of this questionnaire.

FOR MEDICAL OFFICE USE ONLY

Your company has notified us that you could potentially be exposed to the following substance(s):

☐ Asbestos*	☐ beta-Naphylamine	☐ N-Nitrosodimethylamine	☐ Cotton dust
☐ 4-Nitrobiphenyl	☐ Benzidine	☐ Vinyl chloride	☐ 1,2 dibromo 3-chloropropane
☐ alpha-Naphthylamine	☐ 4-Aminodiphenyl	☐ Inorganic arsenic	☐ Acrylonitrile
☐ Methyl chlormethyl ether	☐ Ethyleneimine	☐ Lead	☐ Ethylene oxide
☐ 3.3 -Dichlorobenzidine (and its salts)	☐ beta-Propiolactone	☐ Cadmium	☐ Formaldehyde
	☐ 2-Acetylaminofluorene	☐ Benzene	☐ Methylene dianiline
☐ bis-Chloromethyl ether	☐ 2-Dimethylaminoazobenzene	☐ Coke oven emissions	☐ Other_____

***If you are exposed to asbestos, you will need to complete the asbestos screening questionnaire.**

Allina Health

MEDICAL SCREENING QUESTIONNAIRE

AOH200 (05/15)

PATIENT LABEL

DEMOGRAPHIC HISTORY

Date _____
Name _____
SSN _____
DOB _____ Age _____
Home Address _____
_____
Current Employer _____
Job Title _____
_____

☐ **Check here if you want a copy of your test results forwarded to your personal physician.**

You must complete an "Authorization for Release of Information" form to release your records.

Personal M.D. _____
Address _____
_____
_____

FAMILY HISTORY

If your parents, brothers, sisters, or children have had any of the conditions below, please check corresponding box and explain.

- ☐ Allergy *(asthma, eczema, hay fever)*
- ☐ Arthritis
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Cancer or Leukemia
- ☐ Carpal Tunnel Syndrome
- ☐ Cirrhosis or Liver Disease
- ☐ Congenital Malformation
- ☐ Diabetes
- ☐ Epilepsy *(seizures)*
- ☐ Hearing Problem
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Migraine Headache
- ☐ Sickle Cell Disease
- ☐ Tuberculosis
- ☐ Mental Illness
- ☐ Alcoholism
- ☐ _____

Explain _____
_____

SOCIAL HISTORY

(N) (Y) Do you smoke? How long? _____ How much? _____
(N) (Y) Does anyone else smoke in your household?
(N) (Y) Do you drink? How much? _____
(N) (Y) Do you use recreational drugs? Type _____ Amount _____
(N) (Y) Does anyone in your family work in a job that involves exposure to lead or asbestos?
(N) (Y) Are there any factories or public landfills near your home?
(N) (Y) Have there been reports of a serious pollution problem in your area?
(N) (Y) Have you ever changed your residence or home because of a health problem?
(N) (Y) Do you have city water?
(N) (Y) Do you have your own well?
(N) (Y) Do you work on your own brakes?

At home, do you work with:

(N) (Y) Household cleaners?
(N) (Y) Pesticides?
(N) (Y) Herbicides?
(N) (Y) Are you involved in farming activities?

Explain any YES answers _____
_____

IMMUNIZATION HISTORY (Please indicate any vaccines you have received)

Immunization	YES	NO	Date:
Tetanus			
Hepatitis A			FIRST DOSE / SECOND DOSE
Hepatitis B			FIRST DOSE / SECOND DOSE / THIRD DOSE
Hepatitis B Immune globulin *(HBIG)*			
Mantoux *(Tuberculin)* test			RESULTS: POSITIVE ☐ NEGATIVE ☐

Allina Health

MEDICAL SCREENING QUESTIONNAIRE

AOH200 (05/15)
Page 1

PATIENT LABEL

NAME _____
Date _____ SSN _____
Company _____
Examination _____

HEIGHT	WEIGHT	PULSE	BLOOD PRESSURE (sitting)

URINALYSIS: *(dip stick)*
☐ Negative ☐ Positive

ABNORMAL FINDINGS:
☐ Glucose ☐ Protein ☐ Blood
☐ Other _____

RANDOM BLOOD SUGAR _____

VISION W/O GLASSES:
Distant *(standard type only)*:
_____ R _____ L _____ Both
Near vision values:
_____ R _____ L _____ Both

VISION WITH GLASSES/CONTACTS
Distant *(standard type only)*:
_____ R _____ L _____ Both
Near vision values:
_____ R _____ L _____ Both

COLOR VISION
☐ Ishihara
Results _____
_____
_____
Primary
☐ N ☐ A

CHECK (✔) WHETHER: Normal (N) Abnormal (A) Not Performed (O)

	N	A	O	ABNORMAL FINDINGS
1. Development				
2. Skin				
3. Eyes				
4. Ears				
5. Nose & Sinuses				
6. Throat				
7. Teeth & Gums				
8. Thyroid Gland & Neck				
9. Lymph Glands				
10. Chest				
11. Lungs				
12. Heart				
13. Abdomen				
14. Inguinal rings				
15. Spine				
16. Extremities				
17. Neurological, General				
18. Personality, General				

Comments _____
_____

Health Care Provider _____ **Date** _____
Signature

Health Care Provider _____
Print Name

Allina Health

MEDICAL SCREENING QUESTIONNAIRE

AOH200 (05/15)

PATIENT LABEL

REPRODUCTIVE HISTORY (Females Only)

(N) (Y) Have you ever had problems with infertility or an inability to have children?
(N) (Y) Have you ever delivered a child that was stillborn?
(N) (Y) Have you ever delivered a child with birth defects?
(N) (Y) Have you ever had a miscarriage?
(N) (Y) Do you have any concerns about your reproductive health?

Explain YES answers _____

_____

REPRODUCTIVE HISTORY (Males Only)

(N) (Y) Have you ever had problems with infertility or an inability to have children?
(N) (Y) Have you ever fathered a child that was stillborn?
(N) (Y) Have you ever fathered a child with birth defects?
(N) (Y) Do you have any concerns about your reproductive health?

Explain YES answers _____

_____

I hereby certify that I have answered the questions above to the best of my knowledge and that the answers are true and complete. I authorize Occupational Health Program to release this information to my employer. I also authorize Occupational Health Program to release medical record information concerning me to my employer, including, but not limited to, the results of the history, physical examination, labs and other tests *(including drug and alcohol testing)* that Allina Hospitals & Clinics perform, and my health care provider's opinion regarding my ability to perform the job for which I am undergoing examination.

Employee/Applicant _____ **Date** _____
Signature

Health Care Provider _____ **Date** _____
Signature

Health Care Provider _____
Print Name

OCCUPATIONAL HISTORY

Have you ever worked at or in any of the following occupations?

	YES	NO		YES	NO
Mining			Asbestos		
Pottery			Quarry and Stone Cutting		
Sand Blasting			Welding		
Foundry			Car Body Repair or Lead Grinding		
Brick Manufacturing			Radiation Materials Exposure		
Glass Manufacturing					

Explain any YES answers _____

_____

What types of physical demands or exposures were present in past work positions?

- ☐ Standing 7-8 hours a day
- ☐ Fine hand movements (Repetitive/changes of position)
- ☐ Close eye work (i.e. microscopic, other)
- ☐ Twisting of wrists (Constant or periodic/heavy or light)
- ☐ Frequent lifting greater than 50 pounds
- ☐ Twisting of back
- ☐ Exposure to hazardous materials (i.e. chemicals, excessive heat, radiation)
- ☐ Driving vehicle (Cars, trucks, forklifts)
- ☐ Kneeling, squatting
- ☐ Operating machinery
- ☐ Exposure to loud noises

- ☐ Acetates
- ☐ Acids
- ☐ Acrylics
- ☐ Acrylonitrile
- ☐ Alcohols
- ☐ Alkylating Agents
- ☐ Ammonia
- ☐ Antimony
- ☐ Arsenic
- ☐ Asbestos
- ☐ Benzene
- ☐ Benzidine Dyes
- ☐ Beryllium
- ☐ Bismuth
- ☐ Boranes
- ☐ Bromine
- ☐ Butadiene
- ☐ Cadmium
- ☐ Carbon Tetrachloride
- ☐ Carbon Disulfide
- ☐ Chlorinated Naphthalenes
- ☐ Chlorine
- ☐ Chloroform
- ☐ Chlorophenois
- ☐ Chromates
- ☐ Chromium
- ☐ Cobalt
- ☐ Cold *(severe)*
- ☐ Copper
- ☐ Creosote
- ☐ Cyanide
- ☐ Dibenzofurans
- ☐ Dioxin
- ☐ Epichlorohydrin
- ☐ Epoxy Resins
- ☐ Ethylene Dibromide
- ☐ Ethylene Glycol
- ☐ Ethylene Oxide
- ☐ Fiberglass
- ☐ Fluorine
- ☐ Formaldehyde
- ☐ Fungicides
- ☐ Glycidyl Ethers
- ☐ Glycols
- ☐ Glycol Ethers
- ☐ Gold
- ☐ Halothane
- ☐ Heat *(severe)*
- ☐ Hexane
- ☐ Herbicides
- ☐ Hydrazine
- ☐ Noise *(severe)*
- ☐ Organophosphates
- ☐ PBBs
- ☐ PCBs
- ☐ Perchlorethylene
- ☐ Pesticides
- ☐ Phenol
- ☐ Phosphorous
- ☐ Hydrofluoric Acid
- ☐ Iodine
- ☐ Isocyanates *(MDI, TDI)*
- ☐ Ketones *(MEK)*
- ☐ Lead
- ☐ Magnesium
- ☐ Manganese
- ☐ Mercaptans
- ☐ Mercury
- ☐ Metal Carbonyls
- ☐ Methylene Chloride
- ☐ Molybdenum
- ☐ Nickel
- ☐ Nitrates
- ☐ Nitriles
- ☐ Nitro Compounds
- ☐ Plastics *(unset)*
- ☐ Radiation
- ☐ Resins *(unset)*
- ☐ Rock Dust
- ☐ Selenium
- ☐ Silica Dust
- ☐ Silver
- ☐ Solvents
- ☐ Styrene
- ☐ Talc
- ☐ Tellurium
- ☐ Tin
- ☐ Thallium
- ☐ Trichloroethylene
- ☐ Trichloroethane
- ☐ Tungsten
- ☐ Uranium
- ☐ Urea-formaldehyde
- ☐ Urethanes
- ☐ Vanadium
- ☐ Vibration
- ☐ Video Display Terminal
- ☐ Vinyl Chloride
- ☐ Welding Fumes
- ☐ X-Rays
- ☐ Zinc
- ☐ Zirconium

MEDICAL HISTORY QUESTIONNAIRE

This list refers to conditions or symptoms you have now or may have had in the past. Check YES or NO as appropriate. The interviewer will review all positive responses with you.

GENERAL

- (N) (Y) Bleeding Tendencies
- (N) (Y) Blood Disorder
- (N) (Y) Cancer or Leukemia
- (N) (Y) Diabetes
- (N) (Y) Gout
- (N) (Y) Thyroid Disorder

MUSCULOSKELETAL

- (N) (Y) Fractures
- (N) (Y) Pain w/Bending Forward
- (N) (Y) Sprains
- (N) (Y) Arthritis
- (N) (Y) Myositis
- (N) (Y) Chronic Soreness/Pain in Muscles
- (N) (Y) Joint Pain, Stiffness or Swelling
- (N) (Y) Amputations
- (N) (Y) Bone Infection *(Osteomyelitis)*
- (N) (Y) Muscle Weakness
- (N) (Y) Atrophy
- (N) (Y) Degenerated/Herniated Disc
- (N) (Y) Neck or Back Injury
- (N) (Y) Chronic Neck or Back Pain
- (N) (Y) Neck or Back Stiffness
- (N) (Y) Pain or Numbness down Arm or Leg
- (N) (Y) Pain with Lifting
- (N) (Y) Dislocations
- (N) (Y) Pain w/Twisting
- (N) (Y) Tendinitis
- (N) (Y) Epicondylitis
- (N) (Y) Carpal Tunnel
- (N) (Y) Ulnar Nerve Entrapment
- (N) (Y) Problems with Hand or Wrist

EYE-EAR-NOSE-THROAT

- (N) (Y) Visual Defect *(Color, Depth, Acuity)*
- (N) (Y) Cataract
- (N) (Y) One-Eyed Vision
- (N) (Y) Glaucoma
- (N) (Y) Hearing Loss
- (N) (Y) Tinnitus *(ringing in ears)*
- (N) (Y) Vertigo *(inner ear or balance problem)*
- (N) (Y) Ear Ache
- (N) (Y) Nose Bleeds
- (N) (Y) Hoarseness
- (N) (Y) Nasal Ulcer
- (N) (Y) Nasal Obstruction
- (N) (Y) Dentures
- (N) (Y) Bleeding Gums

RESPIRATORY

- (N) (Y) Trouble or Discomfort with Breathing
- (N) (Y) Shortness of Breath
- (N) (Y) Wheezing
- (N) (Y) Asthma
- (N) (Y) Trouble Breathing While Lying Down
- (N) (Y) Trouble Breathing at Night
- (N) (Y) Chronic Cough *(at least 3 months out of a year)*
- (N) (Y) Excessive Sputum
- (N) (Y) Coughing up Blood or Bloody Sputum
- (N) (Y) Chronic Bronchitis or Emphysema
- (N) (Y) Pleurisy
- (N) (Y) Pneumonia
- (N) (Y) Pulmonary Embolus *(Blood Clot in Lung)*
- (N) (Y) Pneumothorax *(Collapsed Lung)*
- (N) (Y) Abnormal Chest X-Ray
- (N) (Y) Occupational Lung Disease *(Silicosis, etc.)*
- (N) (Y) Abnormal Lung Function Test

CARDIOVASCULAR

- (N) (Y) Palpitation
- (N) (Y) Rapid Heart Rate
- (N) (Y) Irregular Rhythm
- (N) (Y) Chest Pain *(Angina)*
- (N) (Y) Trouble Breathing during Exertion
- (N) (Y) Murmur
- (N) (Y) Heart Attack, Heart Failure, or Other Heart Disease
- (N) (Y) Hypertension
- (N) (Y) Rheumatic Fever
- (N) (Y) Abnormal EKG
- (N) (Y) Heart Surgery
- (N) (Y) Leg Cramps With Walking
- (N) (Y) Phlebitis
- (N) (Y) Poor Circulation

GASTROINTESTINAL

- (N) (Y) Trouble Swallowing
- (N) (Y) Heartburn
- (N) (Y) Nausea and/or Vomiting
- (N) (Y) Abdominal Pain or Colic
- (N) (Y) Irritable Bowel Syndrome
- (N) (Y) Polyps
- (N) (Y) Vomiting up Blood *(red, or like coffee grounds)*
- (N) (Y) Rectal Bleeding
- (N) (Y) Black Tarry Stools
- (N) (Y) Hemorrhoids or Fissures
- (N) (Y) Pancreatitis
- (N) (Y) Changes in Bowel Habits
- (N) (Y) Peptic Ulcer
- (N) (Y) Jaundice
- (N) (Y) Liver Disorder or Disease

GENITOURINARY

- (N) (Y) Abnormal Color of Urine
- (N) (Y) Urinary Frequency
- (N) (Y) Blood or Protein in Urine
- (N) (Y) Discomfort during Urination
- (N) (Y) Prostate Enlargement
- (N) (Y) Dribbling
- (N) (Y) Discharge
- (N) (Y) Kidney Disease
- (N) (Y) Incontinence
- (N) (Y) Urinary Infection
- (N) (Y) Stones

SKIN

- (N) (Y) History of Cancer or Precancerous Lesion
- (N) (Y) Chronic or Recurrent Dermatitis or Eczema
- (N) (Y) Skin Allergy
- (N) (Y) Hives
- (N) (Y) Dry Skin
- (N) (Y) Tendency to Perspire Heavily
- (N) (Y) Water Blisters on Fingers
- (N) (Y) Dermatitis from Cutting or Machine Fluids
- (N) (Y) Acne
- (N) (Y) Frequent Boils
- (N) (Y) Seborrhea *(Dandruff or Flaking of Skin)*
- (N) (Y) Trouble Wearing Gloves
- (N) (Y) Psoriasis

NEUROLOGIC

- (N) (Y) Epilepsy *(Seizure or Convulsions)*
- (N) (Y) Loss of Consciousness
- (N) (Y) Dizziness
- (N) (Y) Paralysis
- (N) (Y) Tremor
- (N) (Y) Abnormal Gait
- (N) (Y) Headaches
- (N) (Y) Numbness or Tingling
- (N) (Y) Burning or Lightning Pains
- (N) (Y) Incoordination
- (N) (Y) Loss of Strength
- (N) (Y) Sensitivity to Cold or Heat
- (N) (Y) Stroke

PSYCHIATRIC

- (N) (Y) Claustrophobia
- (N) (Y) Memory Change
- (N) (Y) Trouble w/Decisions
- (N) (Y) Sleep Disturbance
- (N) (Y) Nervous Breakdown
- (N) (Y) Thoughts of Suicide
- (N) (Y) Excessive Fatigue
- (N) (Y) Drug or Alcohol Abuse
- (N) (Y) Trouble with Sex Life
- (N) (Y) Social Withdrawal
- (N) (Y) Hallucinations
- (N) (Y) Anxiety
- (N) (Y) Depression
- (N) (Y) Crying Spells
- (N) (Y) Loss of Appetite

MENSTRUAL/BREAST (Females Only)

- (N) (Y) Breast Masses or Lumps
- (N) (Y) Breast Pain or Tenderness
- (N) (Y) Nipple Discharge
- (N) (Y) Abnormal Menses
- (N) (Y) Vaginal Discharge
- (N) (Y) Pelvic Pain
- (N) (Y) Menopause
- (N) (Y) Pregnant

Last Menstrual Period _____

Last Pap Smear _____ Result _____