Northwestern Memorial Physicians Group

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MEDICAL QUESTIONNAIRE FOR EMPLOYEES

The information you provide in this questionnaire is strictly confidential and will not be released to any other entity without your specific, written authorization.

PATIENT INFORMATION

Name: _____ **Birth Date:** _____

Phone Number: _____ **Social Security Number:** _____

Address: _____ **City, State, Zip:** _____

Job Title & Department: _____ **Manager/Supervisor:** _____

Birth Place: _____ **Did you attend high school and/or college in the US?** ☐ Yes ☐ No

HEALTH INFORMATION

Please list any medications, prescription or over-the-counter, that you're currently taking: ☐ None

Please list any allergies to medications or other substances, including latex, that you have: ☐ None

Please list any adverse reaction you have ever had to any vaccine or vaccine component: ☐ None

Please check each of the vaccines you've had in the past – documentation supporting your answers is required: ☐ None

- ☐ Diphtheria/tetanus
- ☐ Diphtheria/tetanus/pertussis
- ☐ Hepatitis B (complete series)
- ☐ Chicken pox (complete series)
- ☐ Shingles
- ☐ Influenza (current season)
- ☐ Measles/Rubeola (complete series)
- ☐ Mumps (complete series)
- ☐ Rubella (complete series)
- ☐ German Measles
- ☐ Pneumococcal vaccine
- ☐ Meningococcal vaccine
- ☐ Typhoid
- ☐ Polio
- ☐ BCG

Please check each of the following symptoms you have experienced within the past week: ☐ None of the following

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Eye redness or drainage
- ☐ Persistent cough with or without sputum/blood production
- ☐ Nausea and/or vomiting
- ☐ Unexplained skin rash
- ☐ Persistent diarrhea with or without bleeding

Please check any of the following symptoms that you have experienced in the last month: ☐ None of the following

- ☐ Blackouts, dizziness, falling
- ☐ Loss of vision or double/blurred vision
- ☐ Change in speech or difficulty swallowing
- ☐ Shortness of breath or wheezing with/without activity
- ☐ Chest pain or tightness with/without activity
- ☐ Swelling of the legs or activity-related pain
- ☐ Difficulty climbing stairs/ladder while carrying 25+ pounds
- ☐ Persistent pain in the neck/back with movement , prolonged sitting, lifting, or bending
- ☐ Pain, weakness, or numbness in the arms, hands, or legs
- ☐ A history of carpal tunnel syndrome, epicondylitis, tendonitis or other form of repetitive motion disease

Please check any of the following items that you have been diagnosed for in the past: ☐ None of the following

- ☐ Asplenia
- ☐ Diabetes
- ☐ Renal failure or dialysis
- ☐ Alcoholism
- ☐ Cirrhosis of the liver
- ☐ HIV/AIDS
- ☐ Chicken pox/Shingles
- ☐ Guillain Barre
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Any cancer including leukemia/lymphoma
- ☐ Tuberculosis (TB)
- ☐ Multiple sclerosis
- ☐ Autoimmune disease such as SLE, RA
- ☐ Congenital immunodeficiency
- ☐ Condition requiring steroid use
- ☐ Condition requiring radiation treatment
- ☐ Any other immunosuppressive issue
- ☐ Blood transfusion within the last 6 mo

MEDICAL QUESTIONNAIRE FOR EMPLOYEES (continued)

Please list any other significant past medical history for which you have been treated, hospitalized, or undergone a surgical procedure. Please include dates. ☐ None

I have honestly answered the above questions to the best of my knowledge. I also agree that I will report to my manager if I develop any signs of an infectious illness when I report to work or during my employment.

Patient Signature **Date**

☐ **Patient Unable to Sign. Reason:**

Authorizing Signature **Relationship** **Date**

OFFICE USE ONLY BELOW THIS LINE

VISION SCREENING

Visual Acuity (Snellen)

Right Eye: ☐ Corrected ☐ Uncorrected

Left Eye: ☐ Corrected ☐ Uncorrected

Color Discrimination (Ishihara)

☐ Pass

☐ Fail

OTHER

☐ BBFE information reviewed

For positive infectious symptoms, please consult a physician.

Provider Comments:

Provider Signature **Date**