

**SKAGIT REGIONAL HEALTH
EMPLOYEE HEALTH SERVICES
VOLUNTEER HEALTH QUESTIONNAIRE**

Name	Last Name _____	First Name _____	Middle _____
Address	Address _____	City _____	Zip Code _____
Date of Birth	_____		
Home Phone	_____		
Social Security Number	ONLY last four digits _____		

Allergies and Sensitivities _____
 Food, Medicine, Environmental etc

Tuberculosis

Date of most recent TB skin test _____ Results _____

History of taking BCG _____ Date _____

History of positive TB skin test? _____ Treatment _____

Medication? _____ Length of Treatment _____

Date of most recent Chest X-ray _____ Result _____

Please circle if you have had any of the following symptoms which were unexplained in the last year:

Fever, Cough, Bloody Sputum, Weakness, Loss of Appetite, Night Sweats, Weight Loss, Fatigue

Dermatological Conditions

Are you allergic to latex? _____ Describe _____

Do you have skin conditions? _____

Immune System Y/N

- _____ Spleenectomy
- _____ Kidney, heart, lung, bone marrow or pancreas transplant
- _____ Currently taking Steroid medication
- _____ Current or recent chemotherapy or radiation therapy
- _____ HIV Infection

Health History Y/N

- _____ Asthma/Wheezing/Chronic Respiratory Problems
- _____ Blurred Vision/Vision Problems
- _____ Carpal Tunnel
- _____ Chest Pain
- _____ Closed Head Injury
- _____ Depression/mental health problems/psychiatric problems
- _____ Diabetes
- _____ Fainting Spells/Dizziness
- _____ Eczema/Skin Problems
- _____ Frequent headaches
- _____ Hearing Loss/Hearing Problems
- _____ Heart Problems
- _____ Hepatitis
- _____ Type A__ Type B__ Type C__
- _____ Liver Problems
- _____ Loss of Memory/Difficulty with Mental Functioning
- _____ Numbness
- _____ Oral Herpes/Cold Sores
- _____ Weakness
- _____ Seizures/Loss of consciousness
- _____ Tendonitis
- _____ Tuberculosis

Current Medications or treatments:

Current medical problems/chronic illness not listed above:

Surgeries:

Neck/Back/Shoulder Assessment Y/N

Do you have neck, back or shoulder pain?

Do you have chronic pain in your back or neck or shoulders?

Have you seen a physician, chiropractor or therapist for these problems in the last two years?

Have you ever had restrictions on your work due to these problems? If yes what were they?

Do you have any current restrictions or limitations?

Arm Wrist Hand Assessment Y/N

Do you have arm, wrist or hand pain?

Do you have chronic pain in your arms, wrists or hands?

Have you seen a physician, chiropractor or therapist for these problems in the last two years?

Have you ever had restrictions on your work due to these problems? If yes, what were they?

Do you have any current restrictions or limitations?

Immunity Profile**Tetanus** Date of last tetanus booster _____ Tdap? _____**MMR and Varicella**

MMR Vaccine #1 Date: _____ Vaccine #2 Date _____

Varicella Vaccine #1 Date: _____ Vaccine #2 Date _____

Laboratory Confirmation of Immunity Rubella _____ Rubeola _____ Mumps _____ Varicella _____

Hepatitis B

Vaccine #1 _____ Vaccine #2 _____ Vaccine #3 _____

Hepatitis B antibody test date _____ Result _____

Hepatitis A

Vaccine #1 _____ Vaccine #2 _____

HEPATITIS B ELECTION AND DECLINATION STATEMENT:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself.

_____ I elect to receive the Hepatitis B vaccine. I will contact the Employee Health

Service at my convenience to have it administered within the next 10 days.

_____ I decline Hepatitis B vaccine at this time due to having completed the series.

Patient Care Staff (Nursing, PT, OT, RT, etc.) and others with exposure opportunities:

_____ I decline hepatitis B vaccine at this time. I understand that by declining this

vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Staff without expected exposure opportunities:

_____ I decline hepatitis B vaccine at this time. If in the future I have occupational

exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series *at no charge* to me.

Employee Signature _____ Date: _____