Lexington Medical Center

Post Offer Medical Questionnaire

The purpose of this evaluation is to screen you for communicable diseases and to determine whether you have any physical, mental, or emotional condition that could affect your ability to perform the job you have been offered. Whenever such condition is identified, we will evaluate, with your input and consideration, reasonable accommodations that may allow you to perform the essential functions of your job safely. This interview is not a comprehensive medical examination to identify hidden disease or to offer medical treatment. Once you have begun your job, we encourage you to establish a relationship with a medical provider in accordance with your specific needs.

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____ County: _____

MAIN TELEPHONE

☐ Cellular ☐ Home ☐ Other: (_____) _____

ALTERNATE TELEPHONE

☐ Cellular ☐ Home ☐ Other: (_____) _____

DATE OF BIRTH *(MM/DD/YYYY)* _____ **AGE** _____ **SEX** ☐ Male ☐ Female

EMERGENCY CONTACT

Name: _____ Relationship: _____

☐ Address same as above Address: _____

City: _____ State: _____ ZIP: _____ Telephone: (_____) _____

PERSONAL PHYSICIAN

Name: _____ Telephone: (_____) _____

EMPLOYMENT INFORMATION

Title of job you have been offered: _____

Department Manager: _____

Anticipated Start Date: _____ Human Resources Recruiter: _____

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Title II of the Genetic Information Nondiscrimination Act (GINA) prohibits employers from asking questions pertaining to genetic testing or family medical history. Please do not disclose any health condition or potential health condition based on genetic testing or family history.

Applicant Consent

I understand my offer of employment is contingent upon the successful completion of the Lexington Medical Center's pre-placement process. I understand that drug testing is a part of the pre-placement process. If the results of my drug test are positive I understand the Human Resources Department will be notified and my application for employment will be withdrawn. An exception will be made for the use of legally prescribed medication, taken under and consistent with the direction of a physician, which I have listed on this form.

I certify that the following information is true to the best of my knowledge. I understand this information will become a part of my confidential medical records in the office of Employee Health Services. I understand and agree that any false statement, omission or misrepresentation on the following questionnaire will be cause for dismissal.

_____ _____

Signature Date

Do you have any medical condition being treated by a doctor or chiropractor? ☐ Yes ☐ No

If yes, please explain:_____

Do you anticipate the need for temporary restrictions in the next year? (i.e. pregnancy, surgery) ☐ Yes ☐ No

If yes, please explain:_____

OCCUPATIONAL HISTORY (List your last three positions, starting with the most recent.)

	Title	Brief Description of Duties
1		
2		
3		

Check all that apply to you. Please comment on all "Yes" numbers below.

1. Do you have any health problems, symptoms, or injuries that might interfere with your ability to do this job?	☐ Yes	☐ No
2. Have you ever worked with any substance that caused you to break out in a rash?	☐ Yes	☐ No
3. Have you ever worked at a task that made you short of breath, cough, or wheeze?	☐ Yes	☐ No
4. Have you ever received medical treatment for an injury at work?	☐ Yes	☐ No
5. Have you ever had to change jobs or work assignments because of a health problem or injury?	☐ Yes	☐ No
6. Have certain types of work caused you significant strain in your limbs (i.e. tendonitis) or back?	☐ Yes	☐ No
7. Have you ever been permanently or temporarily disabled due to an injury or illness at work?	☐ Yes	☐ No
8. Do you have any work restrictions or limitations?	☐ Yes	☐ No

Comment on "Yes" answers by number:			

MEDICAL HISTORY

Please list all inpatient or outpatient admissions. Include surgeries, injuries, and diagnostic procedures, starting with the most recent.

Date	Diagnosis/Injury	Treatment

Are you taking any medications? ☐ Yes ☐ No

Please list all prescription and nonprescription medications you have taken in the last 5 –7 days.

Personal Health History: Do you currently have or have you ever had any of the following conditions? Comment by number on all "Yes" responses, describing your experience in the area below.

	DESCRIPTION	YES	NO		DESCRIPTION	YES	NO
1.	ADHD			38.	High Blood Pressure		
2.	Alcohol Abuse or Dependency			39.	High Cholesterol		
3.	AIDS/HIV+			40.	Hypoglycemia (low blood sugar)		
4.	Allergies – Other (i.e. food, latex, etc.)			41.	Jaundice or Liver Cirrhosis		
5.	Allergies to Detergents/Chemicals			42.	Kidney Disease		
6.	Allergies to Medicine			43.	Knee or Hip Injury/Surgery		
7.	Anemia			44.	Lung Disease		
8.	Angina/Chest Pain			45.	Manic Depression/Bipolar Disorder		
9.	Arthritis			46.	Mental Illness/Psychological Disorder		
10.	Asthma or Wheezing			47.	MRSA (chronic staph infections)		
11.	Back/Neck Injury			48.	Multiple Sclerosis		
12.	Back/Neck Strain			49.	Nerve Disease		
13.	Back/Neck Surgery			50.	Numbness or Tingling of Feet or Hands		
14.	Blood Disorders/Bleed Easily			51.	Osteomyelitis		
15.	Bone, Joint or Muscle Problems			52.	Osteoporosis		
16.	Bowel Disorders			53.	Parkinson's Disease		
17.	Bronchitis or Persistent Cough			54.	Rheumatic Fever		
18.	Cancer			55.	Sciatica		
19.	Carpal Tunnel Syndrome or Surgery			56.	Scoliosis		
20.	Cerebral Vascular Accident (stroke)			57.	Seizures or Epilepsy		
21.	Chronic Fatigue Syndrome			58.	Shingles		
22.	Color Blindness			59.	Short of Breath (while walking)		
23.	Deficiency of Immune System			60.	Shoulder Injury/Bursitis/Rotator Cuff Problems		
24.	Depression			61.	Skin Disorders (rashes/eczema)		
25.	Diabetes			62.	Sleeping Disorders, Insomnia or Narcolepsy		
26.	Diarrhea – Acute or Prolonged			63.	Tendonitis of Arm or Hand		
27.	Drug Dependency			64.	Tennis Elbow or Epicondylitis		
28.	Emphysema			65.	Thrombophlebitis (blood clots)		
29.	Eye or Ear Problems			66.	Thyroid Condition/Goiter		
30.	Fainting Spells/Dizziness			67.	Tuberculosis		
31.	Gall Bladder Problems			68.	Ulcers		
32.	Headaches/Migraines			69.	Varicose Veins		
33.	Hearing Loss			70.	Vision Loss Not Correctable With Glasses		
34.	Heart Disease or Rhythm Problems			71.	Are you afraid of tight or enclosed spaces?		
35.	Hepatitis A B C (circle)			72.	Have you worn a respirator as part of any job before?		
36.	Hernia			73.	Have you ever had problems wearing a respirator?		
37.	Herpes			74.	Do you have any other problems that might interfere with respirator use?		

Comment on "Yes" answers by number:

COMMUNICABLE DISEASES AND IMMUNIZATIONS HISTORY

Illness/Virus	Immunization		Have you had the illness/virus?	
Chicken Pox	☐ Yes	☐ No	☐ Yes	☐ No
Hepatitis B	☐ Yes	☐ No	☐ Yes	☐ No
Measles	☐ Yes	☐ No	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	☐ Yes	☐ No
Rubella	☐ Yes	☐ No	☐ Yes	☐ No
Pertussis	☐ Yes	☐ No	☐ Yes	☐ No
Meningitis	☐ Yes	☐ No	☐ Yes	☐ No
Polio	☐ Yes	☐ No	☐ Yes	☐ No
Diptheria	☐ Yes	☐ No	☐ Yes	☐ No
Tetanus	☐ Yes	☐ No	☐ Yes	☐ No

Have you had a TB skin test in the last year? ☐ Yes ☐ No

Have you had a positive tuberculin (TB) test in the past? ☐ Yes ☐ No

If yes, have you been treated? ☐ Yes ☐ No

Have you had a recent chest X-ray? ☐ Yes ☐ No

If yes, please specify date and location:_____

_____

Medical Release of Information

I understand that if, as a result of my responses on this form or my evaluation by Employee Health Services, Lexington Medical Center believes follow-up information is necessary to complete my placement review or determine my ability to perform the essential functions of my job with or without accommodations, I will be asked to complete an authorization allowing Lexington Medical Center to obtain medical records, including but not limited to mental health records and records of alcohol/or drug abuse diagnosis and treatment. I further understand and agree that my failure to authorize such follow-up information may result in my offer of employment being withdrawn.

_____ _____

Signature Date

_____ _____

Witness Date