CARDINAL HILL REHABILITATION HOSPITAL

HEALTH QUESTIONNAIRE
VOLUNTEER / STUDENT / CROTHALL

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name:______________________________ Date:______________________________

Address:______________________________ Supervisor/Manager:______________________

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Home Phone #:__________________________ Birth Date: __________________________

Social Security #: ______________________

In case of emergency, please notify:

Name:______________________________ Phone:______________________________

Address:______________________________

Primary Physician Name:__________________ Phone:______________________________

HISTORY OF VACCINATIONS / IMMUNITY

CHICKENPOX

Have you ever had Chickenpox (Varicella) or Shingles? ☐Yes ☐No

If no:

Have you received the Chicken pox Vaccine or had a blood test (titer) showing immunity? ☐Yes ☐No

If your answer to both questions is no, you may be susceptible to Chickenpox. If you are exposed to someone with Chickenpox, and you are not immune, you could be contagious to others; and you should refrain from your volunteer or work activities at Cardinal Hill until your doctor says you are no longer contagious to others.

2050 Versailles Road ■ Lexington, Ky 40504 ■ (859) 254-5701 ■ www.cardinalhill.org

<u>MEASLES, MUMPS, RUBELLA</u>

Were you born <u>before</u> 1957 ? ☐Yes ☐No

<u>If no:</u>

Have you received 2 MMRs (measles, mumps, rubella vaccinations)? ☐Yes ☐No

<u>If no or unsure</u>:

Have you ever had a blood test (titer) showing immunity to measles, mumps, and rubella? ☐Yes ☐No

<u>If your answer to all 3 questions is no,</u> *you may be susceptible to measles, mumps, or rubella. If you are exposed to someone with measles, mumps, or rubella, and you are not immune, you could spread these very contagious diseases to our patients or staff. Please contact your doctor and make sure your measles, mumps, and rubella vaccinations are up-to-date before participating in volunteer or work activities at Cardinal Hill.*

Additional vaccinations recommended:

Have you received ALL THREE (3) vaccinations for Hepatitis B? ☐Yes ☐No

Have you received a tetanus booster in the last 10 years? ☐Yes ☐No

If your answer to either question is no, please discuss this with your doctor.

TB HISTORY and QUESTIONNAIRE

Have you ever had a POSITIVE TB SKIN TEST (PPD) reaction? ☐Yes ☐No

If NO, please provide copy of negative TB skin test done within the past 3 months or contact Employee Health nurse at ext 5521 to schedule.

If Yes, please provide documentation from your doctor or the Health Department indicating date and results of last chest x-ray, medical evaluation noting you are free of active TB disease, and any treatment received. Contact Employee Health nurse at 5369 for further information and complete the questionnaire below regarding current signs or symptoms of active TB disease.

In the past year, have you experienced any of the following **unresolved signs/symptoms that lasted more than three 3 weeks?**

	Yes	No	Present at this time
Prolonged cough	___	___	___
Fever or chills	___	___	___
Night sweats	___	___	___
Loss of appetite	___	___	___
Weight loss	___	___	___
Coughing up blood	___	___	___
Lymph node swelling	___	___	___

Employee's Signature : ______________________________ Date: ____________

The following is for Employee Health Only: Mantoux method TB Skin Test (PPD) record.

Copy of recent TB Skin Test (PPD) provided/date__________ OR

Date PPD placed__________ R. or L. forearm (initials)_____

Lot #________________________ Exp date:________________________________

Date read__________ Results____________mm induration. Read by:______________________

Date 2nd Step PPD placed __________ R. or L. forearm (initials)_____

Date read__________ Results____________mm induration. Read by:______________________

TB Questionnaire Only (PPD exempt)_______

Chest x-ray or documentation provided?______ Referred for Medical Evaluation of + PPD?______

Nurse's Signature:____

Manufacturer ______________________________ Lot # ____________________ Exp. Date __________

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