



Employee/Student Health

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SUNY Upstate Medical University  
**Upstate Medical University**

Last Name	First	Middle Initial	Sex	Date of Birth	Social Security Number
Local Address (No. and Street)			City	State	Zip
Home Phone Number					
Place of Birth	Job Title/Volunteer	Department/Unit	Supervisor	Dept Phone	
Emergency Contact		Address		Phone Number	
Family Health Care Provider		Address		Phone Number	

**Family History**

Relationship	Age	Good	Fair	Poor	Chronic Illness	If deceased, cause of death and age
Father						
Mother						
Spouse						
Siblings						
Children						

**Personal Health History**

Have you ever had, or do you have, any of the following? If YES, please specify by number and explain on page 2.

- |  |   |
|--|---|
| <p>1. Chicken pox or shingles..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>2. Measles..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>3. Mumps..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>4. Skin problems or chronic rash..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>5. Eye problems..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>6. Hearing loss or ear problems..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>7. Chronic cough..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>8. Asthma..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>9. Shortness of breath..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>10. Lung problems..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>11. Tuberculosis or positive TB skin test..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>12. Chest pain..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> | <p>13. Heart trouble/attack..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>14. Palpitations/irregular heart beat..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>15. Heart murmur..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>16. High blood pressure..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>17. Stroke or paralysis..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>18. Stomach or intestinal problem..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>19. Liver disease/hepatitis..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>20. Kidney disease..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>21. Weight change..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>22. Thyroid problems..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>23. Shoulder/elbow/wrist/hand pain..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>24. Numbness/tingling of arms or hands..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> |
|--|---|

**Personal Health History (continued)**

- |  | No                       | Yes                      |   | No                       | Yes                      |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 25. Broken bones .....                   | <input type="checkbox"/> | <input type="checkbox"/> | 37. Severe weakness or tiredness.....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Bone or joint problems.....          | <input type="checkbox"/> | <input type="checkbox"/> | 38. Depression or anxiety .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Arthritis/gout .....                 | <input type="checkbox"/> | <input type="checkbox"/> | 39. Emotional or psychiatric problems ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Back pain/injury .....               | <input type="checkbox"/> | <input type="checkbox"/> | 40. Drug or Alcohol dependency .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Numbness/tingling legs or feet ..... | <input type="checkbox"/> | <input type="checkbox"/> | 41. Eating disorder .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Knee pain/injury .....               | <input type="checkbox"/> | <input type="checkbox"/> | 42. Bleeding or blood disorder .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Foot pain/injury .....               | <input type="checkbox"/> | <input type="checkbox"/> | 43. Immune suppression .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Neck pain/injury .....               | <input type="checkbox"/> | <input type="checkbox"/> | 44. Chronic/recurrent infection .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Loss of limb .....                   | <input type="checkbox"/> | <input type="checkbox"/> | 45. Tumor/cancer .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Severe headaches .....               | <input type="checkbox"/> | <input type="checkbox"/> | 46. Anemia .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Dizziness or fainting .....          | <input type="checkbox"/> | <input type="checkbox"/> | 47. Diabetic .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Epilepsy or seizures .....           | <input type="checkbox"/> | <input type="checkbox"/> | 48. Any other illness not listed .....      | <input type="checkbox"/> | <input type="checkbox"/> |

**Habits and Questions Related to Work**

Please Check Each Item, If YES, specify by number and explain:

- |   | No                       | Yes                      |  | No                       | Yes                      |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you on any medications.....  | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever been refused employment for health reasons.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any allergies to medication.....   | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have visual, hearing or other physical limitations.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use other drugs .....   | <input type="checkbox"/> | <input type="checkbox"/> | 13. Are you unable to assume certain body positions.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use alcohol.....  | <input type="checkbox"/> | <input type="checkbox"/> | 14. Are you unable to perform certain motions.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Refused as a blood donor.....  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Is there any reason you cannot fully perform all duties that your employment or volunteer work will require on any shift ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you smoke cigarettes.....   | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you ever had a work related injury or illness.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been hospitalized.....   | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever had:   |                          |                          |
| 8. Have you ever had surgery.....   | <input type="checkbox"/> | <input type="checkbox"/> | a) needlestick/blood or body fluid exposure.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever received treatment or counseling for psychiatric or emotional illness.....                           | <input type="checkbox"/> | <input type="checkbox"/> | b) rash or symptoms related to glove use.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have allergies to certain chemicals, dust, animals, or animal products (animal dander, bedding waste)..... | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

Please list the names of physicians or other health care providers that you have seen in the past three years

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I certify that the information documented on this form is true and complete to the best of my knowledge. I authorize any doctor or health care provider listed above to furnish a complete transcript of my medical record for purpose of processing this health form.

I understand that misrepresentation or omission of facts called for may prevent my employment or be cause for termination if hired. Further, I understand that any offer of employment is contingent upon my ability to perform, with reasonable accommodation, based on a job-related physicians's medical examination, x-ray, and laboratory procedures. Such exam is consistent with business necessity, and requires that you do not pose a direct threat to the health and safety of patients, co-workers or other individuals in the workplace.

Printed name of employee/volunteer applicant: \_\_\_\_\_

Signature of employee/volunteer applicant: \_\_\_\_\_

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Health care provider's summary and elaboration of all pertinent data. Please comment on all positive answers.

Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Dept./Program: \_\_\_\_\_

**CLINICAL EVALUATION: CHECK EACH ITEM IN THE APPROPRIATE COLUMN; "NE" IS NOT EVALUATED**

	Normal	Abnormal	NE	Notes: Describe abnormality with pertinent numeral before comment.
1. General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Neck/thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Lymphatics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Thorax/lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Vascular system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Extremities/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Temperature: \_\_\_\_\_ Blood Pressure: Systolic: \_\_\_\_\_ Diastolic: \_\_\_\_\_ Pulse: \_\_\_\_\_

Gross Hearing: R: \_\_\_\_\_ L: \_\_\_\_\_ Corrected Vision: R: \_\_\_\_\_ L: \_\_\_\_\_

Diagnosis and assessment of medical problems:

- No Medical Problems
- Ongoing medical problems: (Explain)

Limitations/Recommendations: (Further specialist examinations, labwork, x-ray, immunizations, etc.)

- No Limitations
- Limitations: (Explain)

Printed Name of Physician/Health Care Provider: \_\_\_\_\_ Title: \_\_\_\_\_

Physician/Health Care Provider Signature: \_\_\_\_\_

Physician/Health Care Provider Address: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_