UCHealth

EMPLOYEE HEALTH CLINIC

BEFORE USING THIS FORM

- You should be viewing this form using **Adobe Acrobat Reader**. This software is **free** and can be downloaded by clicking here: **http://get.adobe.com/reader/**.
  (*If you are using the preview feature in your e-mail program, or viewing it in another software program, you will have problems completing and sending the form*).

- Install **Adobe Acrobat Reader** on your computer if you don't already have it installed.

- Please **download/save** this form to your computer. Open the form using **Adobe Acrobat Reader**.

- Complete the entire form, answering all questions, and remember to **save** frequently.
  (*If you fail to answer a question or complete the personal information, the form will not allow you to submit it as final.*)

- Please close your form and reopen it to ensure all your data was saved to the form before you email it.

- Attach the completed form and **email** it to: **Employee_Health_South@uchealth.org**.

- If you are unable to submit the form as directed, please print your completed form, scan and email it or please print a blank copy, neatly complete it, then scan and email the form.

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All information on the following 3 pages must be completed.

Occupational Health History & Physical

Name			Occupation / Job Title	
Birthdate*	Age	Gender	Home / Cell Phone	SS #
Home Address				Work Phone
Personal Physician	Physician's Address			Physician's Phone
Current Medical Conditions: ◯ None ◯ Explain Below			Allergies: ◯ None ◯ Explain Below	
Current Medications over the counter or prescription: ◯ None ◯ Explain Below				

*NOTE: All date formats should be entered as mm/dd/yyyy

Social History

Are you currently sensitive to: Loud Noise ◯ Y ◯ N Paints / Solvents ◯ Y ◯ N Vibrating Tools ◯ Y ◯ N Dusts ◯ Y ◯ N Welding Fumes ◯ Y ◯ N

Explain any Yes answers:

We have provided you a copy of your job description to review and sign. After reviewing that document, please complete the following charts as appropriate.

When completing these charts, please only indicate the listed conditions if and only if they could limit your ability to perform some or all of the tasks listed in your job description.

NEURO-PSYCHOLOGICAL SYSTEM	Yes	No
1. Frequent Headaches	◯	◯
2. Dizzy Spells or Fainting	◯	◯
3. Paralysis	◯	◯
CIRCULATORY SYSTEM	**Yes**	**No**
4. Prolonged Tiredness or Fatigue	◯	◯
5. Irregular Heart Beats or Arrhythmia	◯	◯
6. Heart Murmur	◯	◯
7. Varicose Veins / Phlebitis	◯	◯
RESPIRATORY SYSTEM	**Yes**	**No**
8. Shortness of Breath	◯	◯
9. Asthma, Bronchitis or Hay Fever	◯	◯
10. Tuberculosis or Positive Skin Test	◯	◯
11. Immunizations:	◯	◯
*Hepatitis B, Date:		
*Tetanus, Date:		
GENITO-URINARY SYSTEM	**Yes**	**No**
12. Kidney or Bladder Infections	◯	◯
13. Kidney or Bladder Stones	◯	◯
14. Blood, Pus, Sugar or Protein in Urine	◯	◯

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EYES, EARS, NOSE, THROAT	Yes	No
15. Eye Trouble (except glasses)	◯	◯
16. Ear or Hearing Trouble	◯	◯
17. Nose or Sinus Trouble	◯	◯
18. Oral / Dental Problems	◯	◯
MISCELLANEOUS	**Yes**	**No**
19. Malaria or Tropical Diseases	◯	◯
20. Body Pain	◯	◯
21. Skin Disease or Allergy	◯	◯
DIGESTIVE SYSTEM	**Yes**	**No**
24. Stomach or Duodenal Ulcer, Gastritis	◯	◯
25. Hepatitis, Liver Trouble, Jaundice	◯	◯
26. Gall Bladder Trouble	◯	◯
27. Colitis, Intestinal Trouble	◯	◯
28. Bloody Bowel Movements	◯	◯
29. Hernia or Rupture	◯	◯
30. Rectal Trouble or Hemorrhoids	◯	◯
MUSCULOSKELETAL SYSTEM	**Yes**	**No**
31. Joint Pains - Arthritis or Bursitis	◯	◯
32. Fractures	◯	◯
33. Back, Shoulder or Leg Pains	◯	◯
ENDOCRINE (GLANDS) SYSTEM	**Yes**	**No**
34. Thyroid or Goiter Trouble	◯	◯
35. Diabetes	◯	◯

Explain briefly any "YES" and refer to number from page 2:

At present do you have any medical or physical disabilities, permanent or temporary work restrictions, or weight-lifting restrictions?
◯ **Yes** ◯ **No** Please describe & explain any restrictions:
Would these restrictions prevent you from performing your essential job functions?
◯ **Yes** ◯ **No** Please describe & explain any restrictions:

I hereby certify that all information provided by me on this form is correct and complete. I understand that falsifying any information on this form could lead to punishment up to and including termination. I agree to the tests that are necessary to this examination. I authorize the release of past medical information to the physician conducting this examination should that physician deem it necessary in determining my fitness for work. I understand that I will be informed of the results of this information and that, upon my written request, all results will be released to a physician of my choice.

Signed (Type full name above to act as digital signature)

DATE (Format to be entered as mm/dd/yyyy)

University of Colorado Hospital Authority is the sole employer of staff at UCHealth including
Colorado Health Medical Group, Medical Center of the Rockies, Memorial Hospital, Poudre Valley Hospital and University of Colorado Hospital.

You must complete all information on pages 1-3 before emailing your form to Employee_Health_South@uchealth.org

For Office Use Only:
Reviewed By: ______________________ Date: ______________

Form Rev: 07-01-15