Pre-placement Latex Sensitivity Questionnaire

Name ___________________________________________ Date________

1. Do you have any allergies to medication or food? ................. Yes No
   If yes, please list _________________________________________________________________

2. Have you suffered from any of the following?
   - Allergic rhinitis (runny nose) ......................... Yes No
   - Allergic conjunctivitis ................................ Yes No
   - Asthma .................................................. Yes No
   - Difficulty breathing .................................... Yes No
   - Eczema .................................................. Yes No
   - Hives ..................................................... Yes No
   - Seasonal allergies ..................................... Yes No
   - Sinus problems ........................................ Yes No

3. List any medications you take, including inhalers
   ____________________________________________________________

4. Have you ever had any skin rashes or breathing problems after handling, eating or being exposed
to the following:
   - Gloves (latex or vinyl) ..................................... Yes No
   - Band-Aids .................................................. Yes No
   - Balloons, condoms, or other rubber products ................. Yes No
   - Bananas, kiwis, papayas, chestnuts, avocado, passion fruit .... Yes No
   - Potatoes, oranges, peaches, or other tropical fruit .......... Yes No
   - Dental, surgical, or gynecology exams ........................ Yes No

_________________________________________  ____________________________
Your Signature                                     Signature of EHS Provider
GEORGE WASHINGTON UNIVERSITY HOSPITAL
EMPLOYEE HEALTH
202-715-4275 OFFICE, 202-715-4587 FAX
Walk-in hours are 8am – 12 noon and 1pm – 4pm, M-F.

PLEASE BRING IN THE FOLLOWING ITEMS:

☐ Physical Exam
  Physical exam within 3 months of hire date
  or make an appointment with EH.
  ☐ My appointment is ________________

☐ Two TB skin test (PPD)
  1st within one year
  2nd within 3 months of hire date
  ☐ PPD___ placed today, to be read between
    _______________ @_______ and _______________ @__________

☐ Most recent Chest X-Ray if history positive PPD

☐ 2 MMR vaccines or all 3 titers

☐ 2 Varicella vaccine or titer

☐ 3 Hepatitis B vaccines or titer

☐ Tetanus (Td or Tdap)

☐ Influenza vaccine (mandatory)

Thank you,
EH staff
**Pre-Placement Physical Examination**

Name________________________________________________ Male □ Female □ Date of Birth__________________________

Address________________________________________________________________________________________ City__________________________

State______ Zip code_________ Phone_________________________ Social Security #________________________

Email __________________________________________________________ Start Date ____________________________

Department_______________________ Position_______________________ Supervisor_________________________

**Medical History**

Do you have any allergies to food, medications, or other substances? □ No □ Yes □ If yes, please list: ____________________________________________________________

Do you take any medications on a daily basis? □ No □ Yes □ If yes, please list: ____________________________________________________________

Do you have any medical conditions? □ No □ Yes □ If yes, please list: ____________________________________________________________

Have you had any operations? □ No □ Yes □ If yes, please list: ____________________________________________________________

Have you had any work-related injuries or blood/body fluid exposures? □ No □ Yes □ If yes, please list: ____________________________________________________________

**Health Behaviors**

<table>
<thead>
<tr>
<th>For Women</th>
<th>For Men</th>
<th>For Both</th>
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<tbody>
<tr>
<td>Do you practice monthly breast exams? □ Yes □ No</td>
<td>Do you practice monthly testicular exams? □ Yes □ No</td>
<td>Do you drink alcohol? □ Yes □ No</td>
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<tr>
<td>Date of last pap smear: __________</td>
<td>Date of last prostate exam: __________</td>
<td>If yes, how many drinks per week? __________</td>
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<tr>
<td>Date of last mammogram: __________</td>
<td>Date of last colon test: __________</td>
<td>Do you exercise? □ Yes □ No</td>
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<tr>
<td>Date of last colon test: __________</td>
<td></td>
<td>If yes, how many times per week? __________</td>
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**Family Medical History**

Does anyone in your family have: high blood pressure __________, diabetes __________, colon cancer __________, breast cancer __________, heart disease __________, prostate cancer __________
### ASSESSMENT/PLAN:

- PPD planted
- PPD read: _____ Neg: ____ Pos: ____
- CXR ordered
- CXR attached
- ROS for h/o + PPD negative for active disease
- ROS for h/o + PPD positive for active disease
- Respiratory mask: N/A
- PAPR:

  - Style: ______________
  - Size: ______________

- Immunizations reviewed and documentation attached
- Immunization(s) given: Td/Tdap MMR
- Other: __________________________

- Titors ordered: measles mumps rubella
- varicella HBsAb HBsAg

- Color blind test

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### Final Clearance

- Discussed healthy lifestyle: diet/exercise smoke cessation health maintenance:
- Advised to follow-up with PCP regarding:
- Person is qualified to continue to perform the essential functions of the job, with or without accommodation. Accommodation needed, if any:
- Person is not qualified to continue to perform the essential functions of the job, with or without accommodation, for the following reason:

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Signature of Examiner ____________________________ Date ________________

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**Normal (✓)**

- Comments for abnormal findings

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### General appearance

- Skin
- Eyes
- ENT
- Mouth/teeth/gums
- Neck
- Lungs
- Heart
- Abdomen
- Upper extremities
- Lower extremities
- Back/spine
- Neurologic
- Mental status

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Signature of Examiner ____________________________ Date ________________
MEDICAL EVALUATION
FOR RESPIRATOR USE

Name ___________________________________________ Date ________________

Have you worn a respirator mask to care for patients before? □ Yes □ No

Please describe the testing: ____________________________________________________________

Have you had, or do you currently have, any of the following:

- Lung or breathing problems □ Yes □ No
- Heart problems □ Yes □ No
- High blood pressure □ Yes □ No
- Skin problems □ Yes □ No
- Claustrophobia (fear of being in closed places) □ Yes □ No
- Seizures □ Yes □ No
- Any other chronic medical conditions that require treatment □ Yes □ No

Explain any "Yes" answers: ____________________________________________________________________________________________________________

Do you take any medications on a regular basis? □ Yes □ No

Please list: ________________________________________________________________

Do you smoke? □ Yes □ No

For how many years? ________________ Pack per day smoked: ________________

If not current, how many years ago did you quit? ________________

Do you have a beard or mustache? □ Yes □ No

Your Signature ___________________________________________ Signature of EHS Provider ___________________________________________

May use respirator mask without restrictions □ Yes □ No

Restrictions: ________________________________________________________________

Further medical evaluation □ Yes □ No

Not approved for respirator use for the following reason(s): ________________________________

Employee Health Services
George Washington University Hospital
900 23rd Street, NW, Suite G-1092 • Washington, DC 20037
202/715-4275 (Phone)
202/715-4587 (Fax)
TB Skin Test History

Part of the initial screening at GWUH Employee Health is a TB skin test (PPD). It is important for our department to know if you ever had a positive reaction to the test, and any treatment or follow-up that you received. Please answer the following questions so we can determine the best way to screen you.

The BCG vaccine is given to many foreign-born persons during childhood for Tuberculosis (TB) disease prevention. (Please note that the BCG vaccine is NOT the same as the TB skin test (PPD) placed on the forearm and used to screen for TB exposure).

1. Have you ever received the BCG vaccine?  Yes  No

2. Have you ever had a positive PPD (TB) skin test reaction?
   
   Yes  No  If so, when________________

3. If positive, did you have a chest x-ray done?  N/A  Yes  No  If so, when_________

4. Have you ever taken anti-tuberculosis medicine following exposure to TB?
   N/A  Yes  No  If so, when_________
   
   How long did you take this medication for?  _________

5. Have you ever been told you should not receive a TB skin test because of an adverse or allergic reaction?
   Yes  No

6. Do you live with or have you been in close contact with someone who was recently diagnosed with active TB (roommate, close friend, relative)?
   Yes  No

__________________________  __________________________  __________________________
Your Signature  EHS Provider Signature  Date
Should I get the Tdap vaccine?

1. Are you in a healthcare facility in direct contact with patients?  
   □ Yes □ No
   
   (ie: doctor, nurse, therapist, aide, technician, etc.)

2. Are you in close contact with infants?  
   □ Yes □ No
   
   (ie: mother, father, sibling, grandparent)

3. Are you an employee in a school or child-care setting?  
   □ Yes □ No
   
   (ie: babysitter, tutor, coach, bus driver, etc.)

4. Was your last tetanus booster a Td or Tdap?  
   (Please circle one)

Spread of Pertussis has been documented in various healthcare settings, including hospitals and emergency departments serving pediatric and adult patients, outpatient clinics, nursing homes, and long-term care facilities.

Healthcare personnel who have direct patient contact should receive a single dose of Tdap if they have not previously received Tdap as an adult. Tdap can be administered regardless of interval since the previous Td dose. However, shorter intervals between Tdap and last Td may increase the risk of mild local reactogenicity.

Healthcare personnel include but are not limited to physicians, other primary care providers, nurses, aides, respiratory therapists, radiology technicians, students (e.g., medical, nursing, and pharmaceutical), dentists, social workers, chaplains, volunteers, and dietary and clerical workers.

Tdap vaccination can protect healthcare personnel against pertussis and help reduce transmission to others. Priority should be given to vaccinating healthcare personnel who have direct contact with babies younger than 12 months of age.