**GEORGE WASHINGTON UNIVERSITY HOSPITAL**

**EMPLOYEE HEALTH SERVICES**

**OFFICE:** 202 – 715 – 4275  
**FAX:** 202 – 715 – 4587

**REQUIREMENTS FOR CLEARANCE:**

- Physical exam within 3 months of hire.

- 2 TB skin test (PPD)\(\rightarrow\)1\(^{st}\) within one year and the 2\(^{nd}\) within three months of hire.

- If you have a prior history of +PPD, complete the Positive PPD Assessment questionnaire.

- Copy of most recent chest x-ray report if +PPD

- 2 MMR vaccines or titers

- 2 Varicella vaccines or titer

- 3 Hepatitis B vaccines or titer

- Tetanus booster (Td/Tdap)
Employee Health Service
George Washington University Hospital
800 23rd Street, NW, Suite G-1022 • Washington, DC 20037
202/715-4275 (Phone)
202/715-4277 (Fax)

Name ___________________________ □ Male □ Female  Date of birth ______________________

Home address __________________________________ City __________________ State ______ Zip ______

Home/Cell phone ___________________________ Social Security Number __________________________

Position ___________________________ Department ___________________________ Shift __________

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>
</tr>
</thead>
<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>
</tr>
<tr>
<td>Date of last pap smear: ___________</td>
<td>Date of last prostate exam: ___________</td>
<td>If yes, how many drinks per week? _________</td>
</tr>
<tr>
<td>Date of last mammogram: ___________</td>
<td>Date of last colon test: ___________</td>
<td>Do you exercise? □ Yes □ No</td>
</tr>
<tr>
<td>Date of last colon test: ___________</td>
<td></td>
<td>If yes, how many times per week? _________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you smoke now? □ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If yes, how much? _________ ppd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you have regular dental visits? □ Yes □ No</td>
</tr>
</tbody>
</table>

FAMILY MEDICAL HISTORY

Does anyone in your family have: high blood pressure ___________, diabetes ___________, colon cancer ___________, breast cancer ___________, heart disease ___________, prostate cancer ___________
# TO BE COMPLETED BY EXAMINER

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BP</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Normal(%)</th>
<th>Comment for abnormal findings</th>
</tr>
</thead>
</table>

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

**ASSESSMENT/PLAN:**

- ☐ PPD placed
- ☐ Date of PPD ________ Neg: ___ Pos: ___
- ☐ h/o + PPD, documented
- ☐ h/o + PPD, not documented
- ☐ ROS for h/o + PPD negative for active disease
- ☐ ROS for h/o + PPD positive for active disease
- ☐ Respiratory mask fit test: ☐ small
  - ☐ regular
  - ☐ other

  ☐ CXR ordered
  ☐ CXR on file
  ☐ Immunizations reviewed and documentation attached
  ☐ Immunization(s) given: ☐ Td ☐ MMR ☐ Other
  ☐ Titers ordered: ☐ measles ☐ mumps ☐ rubella
  - varicella ☐ HBsAb

  ^ Final Clearance ^

___ 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: ____________________________

Signature of Examiner

__________________________

Date
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

Employee signature ____________________________ Signature of EHS prescriber __________________________

80-820 Rev. 12/03
Annual Assessment for Tuberculosis for Positive PPD Skin Test Reactors

The George Washington University Hospital, in accordance with the Centers for Disease Control (CDC) guidelines, requires an annual screening of all health care employee for tuberculosis. To evaluate those employees who have a documented positive Mantoux/PPD, the CDC recommends that the following questions be asked to determine if an active form of tuberculosis has developed. If the physical examination and survey indicate an active form of tuberculosis, a chest x-ray will be ordered and reviewed. If the physical examination and survey do not indicate active tuberculosis, no further evaluation is necessary.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Date of +PPD</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Treated with INH?</th>
<th>How long?</th>
<th>Date of most recent CXR &amp; results</th>
</tr>
</thead>
</table>

Are you experiencing any of the following symptoms?

- Persistent cough
- Coughing bloody sputum
- Chest pain
- Shortness of breath
- Loss of appetite
- Unexplained weight loss
- Fever and/or chills
- Night sweats

If you answered yes to any of these questions, please explain

__________________________________________________________________________

__________________________________________________________________________

Employee Signature

Date

Based on an evaluation of these responses, the employee does/does not need a chest x-ray at this time.

Provider Signature

Date