MY HOSPITAL
Hilo Medical Center
MY COMMUNITY

Employee Health

Date: _____ Work Phone No. NA

Last Name: _____ First Name: _____

Job Position: Pharmacy Intern Department: Pharmacy

HEALTH APPRAISAL & MEDICAL SURVEILLANCE SCREENING QUESTIONNAIRE

Please indicate whether you currently have any of the following health conditions:

Yes ☐	No ☐	**Positive TB skin test**
Yes ☐	No ☐	Anemia
Yes ☐	No ☐	Bleeding problem (Bleeding or bruises easily; bleeding gums)
Yes ☐	No ☐	Blood Disease
Yes ☐	No ☐	Bowel Problems
Yes ☐	No ☐	Significant changes in your health
Yes ☐	No ☐	Illness that lasted for more than two weeks
Yes ☐	No ☐	Recurrent fevers lasting for more than 5 days
Yes ☐	No ☐	Unexplainable weight loss or weight gain
Yes ☐	No ☐	Persistent night-time perspiration lasting for more than one week
Yes ☐	No ☐	Immune Suppressive Problems
Yes ☐	No ☐	Health problems related to latex exposure
Yes ☐	No ☐	Taking steroid medications within the past month (do not include steroid nasal spray)
Yes ☐	No ☐	Cancer
Yes ☐	No ☐	A physical or medical condition that would prevent you from performing your job duties
Yes ☐	No ☐	A condition that requires work accommodations
Yes ☐	No ☐	Cough greater than one month
Yes ☐	No ☐	Coughing up Blood
Yes ☐	No ☐	Dizziness, Light-headedness, Fainting
Yes ☐	No ☐	Fatigue (unexplained and possibly work-related)
Yes ☐	No ☐	Headaches (unexplained and possibly work-related)
Yes ☐	No ☐	Intestinal Problems (Kidney stones, abnormal Kidney function, pain, etc.)
Yes ☐	No ☐	Liver Problems (hepatitis, enlarge liver, etc.)
Yes ☐	No ☐	Lymph Node Problem (swollen, painful, etc.)
Yes ☐	No ☐	Mouth sores
Yes ☐	No ☐	Nausea/Vomiting
Yes ☐	No ☐	Reproduction Problems
Yes ☐	No ☐	Respiratory Problems (problems breathing, emphysema, shortness of breath)
Yes ☐	No ☐	Skin Disease, skin lesions, open skin sores
Yes ☐	No ☐	Swallowing Problems
Yes ☐	No ☐	Urinating Problems (bloody urine, pain when urinating, etc.)
Yes ☐	No ☐	Voice Problems (hoarseness, problems speaking, etc.)

Reproductive History(only for employees exposed to Anit-Neoplastic drugs: Pharmacy, Housekeeping, Laundry, HPOC and Medical Unit)

Yes ☐	No ☐	Are you of reproductive age?
Yes ☐	No ☐	Are you planning to have children?

☐ **I understand that the TB skin test must be read by a trained and certified Health Care Worker.**

YOUR SIGNATURE:_____ **DATE:**_____