UTHealth
The University of Texas
Health Science Center at Houston

Please complete and email form to HR@uth.tmc.edu

University of Texas Employee Health Clinical Services

Health History Questionnaire Form

TYPE OR PRINT CLEARLY

Name:	Date of Birth: Gender: ☐ Male ☐ Female
Street Address:	City/State/ZIP/Country:
Your Contact Number(s):	Your email:
Your Supervisor or Sponsoring Agency & UTH Department/School:	Job Title:

CONFIDENTIALITY STATEMENT: This form requires that you provide personal health information that is protected by University policy and State and Federal law. Your rights to the confidentiality of your personal health information will be strictly maintained by Employee Health Services. Your information will be used or disclosed in accordance with those policies and laws only to the minimal extent necessary for your treatment or business operations. You have the option of sending the form via regular mail or sending it via interoffice mail to the address above.

If you will be participating in activities at UTHealth longer than one (1) day, please indicate your classification:

( ) Employee ( ) Visiting Student trainee Estimated length of stay ____Months ____ Days
( ) Professional trainee ( ) Visiting Scientist Estimated length of stay ____Months ____ Days
( ) Pre-baccalaureate trainee

Are you working in a laboratory, K-12 school, providing Direct Patient Care or working with the public? ❑ Yes ❑ No ❑ Don't Know Yet (If "Yes", proceed to 1.TB test below. If No, go to Page 2)

Your application will not be considered unless supporting documentation is included:

1. **Tuberculin (TB) skin test (PPD) required within the last 6 months, even if you received BCG vaccine.**
   1.1. Date of last TB skin test:______________ **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**
      1.1.1. Result (mm)__________ Negative______Positive (measurement_________ mm if available)
   1.2. Have you ever had a positive tuberculosis (TB) skin test? _____ Yes ____ No If yes, when? _________
      1.2.1. Chest x-ray findings if PPD is positive (attach x-ray report) Date of chest x-ray: _______________
2. Hepatitis B Series Three-dose series or laboratory report of positive hepatitis surface antibody titer **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**
   2.1. #1 _________ #2 _________ #3 _________
3. Tetanus/Diphtheria or TDAP one dose within the past 10 years. **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**

   Date of last vaccination: ___________________
4. MMR/Measles booster Two (2) doses of measles vaccine if born after January 1, 1957, administered on or after your first birthday and at least 30 days apart. Or laboratory report of positive rubeola, mumps, and rubella titers. #1_________ #2 __________ **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**
5. Varicella vaccine series (2 doses given at least 28 days apart) or Chicken pox disease (documented by health care provider) or positive varicella titer **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**
6. Seasonal influenza vaccination. Date___________________ Attach evidence of vaccination.

Bloodborne Pathogen Exposure Questions:

1. While at The UTHealth, will you be exposed to human blood and bodily fluids? ❑ Yes ❑ No
   1.1. If you are a **visitor** and have a risk of being exposed to bloodborne pathogens while at the University; do you want UTHealth to provide the vaccine series at your expense, or perhaps refer you to another source for the vaccination series?
   1.2. ❑ Yes ❑ No, I have previously received the vaccine series.

If you are an **employee** and will be exposed to bloodborne pathogens here at The University of Texas, we will provide the Hepatitis B vaccine series to you at no charge.

If you are an **employee** do you want the vaccine series? ❑ Yes ❑ No, I have previously received the vaccine series.

<u>If you are an EMPLOYEE and will be exposed to human blood and bodily fluid and choose NOT to accept the vaccine, please read and sign the statement below:</u>

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. I understand that be declining this vaccine, I continue to be at risk of acquiring Hepatitis B infection, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

____ ___________________________

<u>Employee Hepatitis B - Declination Signature</u> **Date**

For employee assigned to <u>HCPC</u>

I understand that HCPC has a mandatory influenza vaccination policy and that I am expected to be vaccinated annually against influenza during my period of employment and may only be excused for reasons of medical contraindication substantiated by a physician.

____ ___________________________

Employee Signature **Date**

Past History and Review of Systems:

Please check if you have ever had any of the following:

- ☐ Skin Problems.
- ☐ Communicable Diseases.
- ☐ Persistent or unusual cough.
- ☐ Color blindness/vision problems
- ☐ Loss of consciousness/seizures/ convulsions
- ☐ Unsteadiness in balance/dizzy spells
- ☐ Diabetes/Sugar disorders
- ☐ Neck/back/knee problems
- ☐ Difficulty with hearing
- ☐ Hepatitis
- ☐ Alcohol/drug abuse
- ☐ Psychiatric/emotional problems/depression/anxiety

For any items checked above, are you or were you under the care of a physician? ❑ Yes ❑ No

Comments:

<u>Signature</u> **(Visitor and / or Employee)** **Date**

_______________________________________ ______________________________________

Office Use Only Seasonal Influenza: ____________ MMR Booster: ____________ Td/TDap Booster _______________

Hepatitis B Vaccine: #1________________ #2______________#3____________________

TB Skin test given: Date __________TB skin test result ____mm Date of reading__________

Sent for CXR: Date__________________ Result: ______________________

☐ Occupational Health Enrollment Form (Working with Animals) ☐ Schedule Spirogram

☐ Respiratory Clearance form for EHS ☐ Fax Respiratory Clearance form to 713.500.5841 ☐ Not cleared