



**EMPLOYEE HEALTH AND IMMUNIZATION HISTORY**

Today's Date: \_\_\_\_\_

Starting Date: \_\_\_\_\_

Full Time       Part Time

**DONE TODAY**

- |                        |                               |
|------------------------|-------------------------------|
| 1. PPD _____           | 4. Varicella Titer _____      |
| 2. Rubella Titer _____ | 5. Chest X-ray _____          |
| 3. Rubeola Titer _____ | 6. Hepatitis B Antibody _____ |
|                        | 7. Other _____                |

Name: Last	First	MI	Home Phone:	
Home Address:			Date of Birth	Sex
Department	Building/Floor/Room #		Telephone #	Shift

**IMMUNIZATION HISTORY**

**A. TB History**

- |   |   |
|---|---|
| 1. Have you ever had Tuberculosis (TB)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, date diagnosed: _____ | 4. Have you ever received BCG vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Date of most recent TB test? _____   | 5. Date of most recent chest x-ray: _____   |
| 3. Was there any redness or swelling? <input type="checkbox"/> Yes <input type="checkbox"/> No                                    |   |

**B. Rubella (German Measles) History**

- Documented physician diagnosis?  Yes  No
- Documented Titer Result?  Yes  No
- MMR Vaccine?  Yes  No Date: \_\_\_\_\_

**C. Rubeola (Measles) History**

- Documented physician diagnosis?  Yes  No
- Documented Titer Result?  Yes  No
- MMR Vaccine?  Yes  No Date: \_\_\_\_\_

**D. Hepatitis History**

- Known history of Hepatitis?  Yes  No  
If yes, what kind?  Hepatitis A  Hepatitis B  Hepatitis C
- Known history of positive Hepatitis antibody titer without history of disease?  Yes  No
- Hepatitis vaccine received elsewhere? If yes, number of injections received? \_\_\_\_\_

**E. Varicella (Chicken Pox/Shingles)**

- Known disease as child?  Yes  No  
Chicken Pox?  Yes  No Date: \_\_\_\_\_ Shingles?  Yes  No Date: \_\_\_\_\_
- Varicella Vaccine Received?  Yes  No Date: \_\_\_\_\_
- Varicella Titer Result:  Positive  Negative Date: \_\_\_\_\_

**F. Tetanus**

- Date of last injection? \_\_\_\_\_

**OCCUPATIONAL HISTORY**

**Previous Employment**

Job Title: \_\_\_\_\_ Date: \_\_\_\_\_ Description of Job Duties: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Date: \_\_\_\_\_ Description of Job Duties: \_\_\_\_\_

Work-Place Exposures:  Dusts (wood, silica, asbestos, metals)  Chemicals (pesticides, acids, etc.)  Radiation (x-rays, radioactive materials)  
 Noise  Heavy Lifting  Biological Agents (microbes, needlesticks)

Accidents:  
 Date(s): \_\_\_\_\_ Type of Accident: \_\_\_\_\_ Injury: \_\_\_\_\_  
 Date(s): \_\_\_\_\_ Type of Accident: \_\_\_\_\_ Injury: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Apical Pressure: \_\_\_\_\_ Lungs: \_\_\_\_\_

Date of Most Recent: \_\_\_\_\_ Eye Exam: \_\_\_\_\_ Physical Exam: \_\_\_\_\_

IS THERE A FAMILY HISTORY OF: YES/ NO

- Diabetes
- Arthritis
- Epilepsy
- Cancer
- High Blood Pressure
- Heart Disease

HAVE YOU EVER HAD: YES/NO

- Diabetes
- Arthritis
- Joint Pain or swelling
- Back trouble
- Hip, knee, or leg injury
- Foot problems
- Epilepsy
- Fainting spells or dizziness
- Headaches

HAVE YOU EVER HAD: YES/NO

- Cancer
- High Blood Pressure
- Heart Condition
- Shortness of Breath
- Angina
- Varicose Veins
- Blood Clots
- Rheumatic Fever
- Thyroid Disease

HAVE YOU EVER HAD: YES/NO

- Anemia
- Jaundice
- Asthma
- Hayfever
- Sinus Problems
- Skin Conditions
- Eczema
- Cough
- Stomach Problems
- Ulcers

HAVE YOU EVER HAD: YES/NO

- Gallbladder disease
- Bowel disease
- Colitis
- Frequent Diarrhea
- Parasites
- Kidney Disease
- Cystitis or frequent urinary infections
- Breast cysts
- Irregular menstrual periods
- Pain with periods

DO YOU: YES/NO

- Need glasses to read or for distance
- Wear contact lenses
- Ever use a hearing aid
- Take medication regularly
- Smoke (how much?)
- Use Alcohol (how much?)

HAVE YOU EVER? YES/NO

- Been operated on
- Been hospitalized
- Had a work-related injury or illness
- Received workers' compensation
- Worked with radioactive material

KNOWN MEDICATION ALLERGY

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CURRENT MEDICATION(S):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If yes to ANY of the above, please explain:

\_\_\_\_\_

\_\_\_\_\_

Will you be working with any of the following human blood, human blood derived cells, or body fluids?

- blood  cell lines  cerebral spinal fluid  synovial fluid  pleural fluid  peritoneal fluids  pericardial fluids  amniotic fluids  semen  vaginal fluids
- no  unsure

Will you be working with animals or live organisms:  yes, list: \_\_\_\_\_  no  unsure

Will you be working with chemicals:  yes, list: \_\_\_\_\_  no  unsure

Please identify any hazardous materials that you will be working with that are not listed above: \_\_\_\_\_

Other Problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

BOSTON UNIVERSITY  
 OCCUPATIONAL HEALTH CENTER  
 930 Commonwealth Avenue, West  
 Boston, MA 02215

Phone: (617) 353-6630  
 Fax: (617) 353-6848

Hours of Service  
 9:00 a.m. – 5:00 p.m. (M-F)

**REVIEW OF SYSTEMS/PHYSICAL ASSESSMENT**

**Employee Name:** \_\_\_\_\_ **Department:** \_\_\_\_\_

Height: _____	BP: _____
Weight: _____	Pulse: _____

<b>KEY</b>
○ = WNL
+ = Positive Findings

**Patient Comments  
(Yes or No)**

**Findings**

<b>General</b>	weight change, fatigue, weakness, fever, appetite changes		
<b>Skin</b>	rashes, masses, ulcerations, persistent sore, changing moles		
<b>Head</b>	head injury, dizziness, frequent headaches		
<b>Eyes</b>	blurry vision, tearing, double vision, discharge, trauma		
<b>Ears</b>	hearing loss, ringing, frequent infections, drainage		
<b>Nose/Sinuses</b>	congestion, epistaxis, hay fever, frequent colds		
<b>Mouth/Throat</b>	sore throats, hoarseness, sores, dental exams		
<b>Neck</b>	lymphadenopathy, goiter		
<b>Breasts</b>	lumps, nipple discharge, pain, self examination		
<b>Respiratory</b>	persistent cough, dyspnea, sputum, hemoptysis, wheezing, infections		
<b>Cardiac</b>	HTB, MI, heart murmur, rheumatic fever, chest pain, palpitations		

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		<b>Patient Comments (Yes or No)</b>	<b>Findings</b>
<b>Gastro-Intestinal</b>	indigestion, nausea & vomiting, heartburn, diarrhea, constipation, bleeding		
<b>Urinary</b>	dysuria, burning, frequency, incontinence, nocturia, hematuria, UTI, history of stones		
<b>Reproductive</b>	STD's, Male: hernia, testicular pain, self examination Female: menstrual problems, yeast infections		
<b>Musculo-Skeletal</b>	joint pain/stiffness, gout, arthritis, back pain, scoliosis, kyphosis		
<b>Peripheral Vascular</b>	cramps, varicose veins, thrombophlebitis		
<b>Neurological</b>	fainting, tremors, paralysis, local weakness, paresthesia		
<b>Psychiatric/Emotional</b>	nervousness, mood changes, tension, depression		
<b>Endocrine</b>	polyuris, heat/cold, polyphagia, intolerance, polydipsia		
<b>Hematologic</b>	easy bruising, bleeding, disorder		

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Nurse Practitioner:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## MANTOUX TEST FOR TUBERCULOSIS

It is the policy of the Boston University Occupational Health Center that all employees be screened for Tuberculosis with a Mantoux (PPD) test at the time of their pre-placement physical exam, annually thereafter as required, and after an exposure to Tuberculosis.

Screening will be performed by the Occupational Health Center or designated alternate and read 48-72 hours after the test. If the test is not read at the appropriate time, it will be repeated. Employees may not read their own skin test. If needed, a chest x-ray will be done. The employee's work status will be determined by the result of the x-ray report.

**Please answer the following:**

	YES	NO
1. Have you ever had a reaction to Mantoux (PPD) testing?	_____	_____
2. Have you taken steroids (Cortisone, Prednisone) within the last thirty (30) days?	_____	_____
3. Have you received an immunization within the last thirty (30) days?	_____	_____

\_\_\_\_\_  
**Employee's Signature**

\_\_\_\_\_  
**Date**

Lot #: \_\_\_\_\_

Expiration: \_\_\_\_\_

Given by: \_\_\_\_\_

Date Given: \_\_\_\_\_

Read by: \_\_\_\_\_

Date Read: \_\_\_\_\_

Results (check appropriate line)

\_\_\_\_\_ Negative – no irritation (swelling)

\_\_\_\_\_ Erythema (redness only)

\_\_\_\_\_ Positive or indeterminate-induration (swelling) is present\*

Measure and record induration (not redness) \_\_\_\_\_ mm.

\*All employees with a positive reaction must report to the Occupational Health Center for evaluation.

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## SCREEN FOR TUBERCULOSIS SYMPTOMS

**Employee's Name (First, Last, MI):** \_\_\_\_\_

**Employer's Name** \_\_\_\_\_

If your tuberculosis (TB) skin test (PPD) result was positive it is necessary to screen for signs and symptoms of active TB disease for healthcare workers. Active TB disease may occur anytime after infection has taken place.

Please answer the questions below. An occupational health practitioner will review your answers to determine if there are any indications that you have active TB. Thank you for your cooperation. If you have any questions, please let us know.

Do you currently have any of these symptoms?

	YES	NO
Unintentional weight loss >10lbs		
Loss of appetite		
Becoming easily tired without apparent reason		
Coughing up sputum		

	YES	NO
Coughing up blood		
Night Sweats		
Fever for more than 2 weeks		

If you answered "Yes" to Coughing, please describe how frequently you are coughing and if you are producing any phlegm and/or blood when you cough:

\_\_\_\_\_

If you answered "Yes" to any of the other questions, please list any possible explanations for these symptoms:

\_\_\_\_\_

Have you ever received medication for a positive skin test?

Yes

No

If "Yes," for how long did you take the medication?

\_\_\_\_\_

\_\_\_\_\_  
**Employee's Signature**

\_\_\_\_\_  
**Date**

## TETANUS/DIPHTHERIA VACCINATION FORM

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

### What is Tetanus?

Tetanus, or lockjaw, results when wounds are infected with tetanus bacteria, which is often found in dirt. The bacteria in the wound make a poison that causes muscles to go into spasm. In the United States, about 30% of people who get tetanus die of it.

### What is Diphtheria?

Diphtheria is a very serious disease that can affect people in different ways. It can cause an infection in the nose and throat that can interfere with breathing. It can also cause an infection of the skin. Sometimes it causes heart failure or paralysis. About 5-10% of people who get diphtheria die of it.

### What are the Risks of Tetanus/Diphtheria Vaccination?

Side effects from tetanus/diphtheria vaccine are uncommon and usually consist only of soreness and slight fever. As with any drug or vaccine, there is a rare possibility that allergic or more serious reactions or even death could occur.

### Contraindications and Precautions for Tetanus/Diphtheria Vaccination

#### Contraindications:

- First trimester of pregnancy
- History of a neurologic reaction or severe allergic reaction (e.g. generalized rash or anaphylaxis) after a previous dose of tetanus diphtheria vaccine

#### NOT Contraindications: (vaccine may be given)

- Second and third trimesters of pregnancy
- Breastfeeding

\_\_\_\_\_  
Signature (Consent to Receive Tetanus/Diphtheria Vaccine)

\_\_\_\_\_  
Date

Lot #: \_\_\_\_\_ Injection Site: \_\_\_\_\_ Practitioner's Initials: \_\_\_\_\_