Stony Brook Eastern Long Island Hospital

♦ **Employee Health**

EMPLOYEE HEALTH HISTORY

This form must be on file in Health folder of all Employees, Physicians, Volunteers, and Students.

NAME: _____ DATE OF BIRTH: _____

E-Mail: _____ TODAYS DATE: _____

DEPT/POSITION: _____ TELEPHONE: _____

ADDRESS: _____

Emergency Contact: (please notify):

Name: _____ Relationship: _____

Address: _____ Telephone: _____

FAMILY HISTORY:

	Age	If Living, Health Problems	Age at Death	If Deceased, Cause
Mother:				
Father:				
Siblings:				

Blood Relatives who have or had (check and indicate relationship)

- ☐ Arthritis: _____
- ☐ Asthma: _____
- ☐ Bleeding Tendency: _____
- ☐ Cancer: _____
- ☐ Colitis: _____
- ☐ Congenital Heart: _____
- ☐ Diabetes: _____
- ☐ Epilepsy: _____
- ☐ Goiter: _____
- ☐ Heart Attack: _____
- ☐ High Blood Pressure: _____
- ☐ Kidney Disease: _____
- ☐ Leukemia: _____
- ☐ Migraine: _____
- ☐ Rheumatic Heart: _____
- ☐ Stroke: _____
- ☐ Tuberculosis: _____
- ☐ Ulcers: _____

WOMEN:

Are your menstrual periods regular?	☐ YES	☐ NO
Are your menstrual periods painful?	☐ YES	☐ NO
Do you miss time from work or school because of your period?	☐ YES	☐ NO

Date of your last period: _____

Number of Pregnancies: _____

Were there any complications during or after pregnancies?	☐ YES	☐ NO

If YES, explain _____

Are you pregnant now?	☐ YES	☐ NO
Do you take oral contraceptives?	☐ YES	☐ NO

CHILDHOOD ILLNESSES: (check yes or no)

☐ YES	☐ NO	Measles	☐ YES	☐ NO	Mumps
☐ YES	☐ NO	Chicken pox/ shingles	☐ YES	☐ NO	Diphtheria
☐ YES	☐ NO	German Measles	☐ YES	☐ NO	Rheumatic Fever
☐ YES	☐ NO	Whooping cough	☐ YES	☐ NO	Polio

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Name: _____ **Date:** _____

ALLERGIES:

Do you have any allergies and/or sensitivities to any medications, food, LATEX, plants or chemicals? ☐ YES ☐ NO

Please list all known allergies to:

Medications: _____

Foods: _____

Environmental: _____

Other: _____

MEDICATION:

Are you taking any medications now that might affect your clinical judgment or motor skills? ☐ YES ☐ NO

If "Yes," give details: _____

Other medications you are now taking: _____

HEALTH HABITS:

Do you smoke? ☐ YES ☐ NO If YES, # packs /day _____

Do you consume any alcoholic beverages? ☐ YES ☐ NO If "Yes," how much? _____

Exercise Habits: _____

Sleep Habits: _____

ADULT ILLNESSES:

Psychiatric: _____

Operations: _____

Injuries: _____

Chronic Ailments: _____

IMMUNIZATION HISTORY: Please list date of last immunization

DPT: _____ Tetanus: _____ Mumps: _____

Polio: _____ Measles: _____ Smallpox: _____

BCG: _____ German measles: _____ Hepatitis B: _____

Have you had the Tdap booster? ☐ YES* ☐ NO If YES, Date: _____

* Please provide documentation

Have you had a Flu Vaccine: ☐ YES ☐ NO

If YES, please **provide documentation** and indicate when and where: _____

If NO, would like to have a flu vaccination at this time (if during flu season): _____

Were you ever skin tested for TB? ☐ YES ☐ NO

If YES, date of last test for TB: _____

If YES, was the reaction positive or negative? : _____

MEDICAL HISTORY:

Have you had any illness, injury, or surgery (other than a simple cold, etc.) lasting longer than 3 days? ☐ YES ☐ NO

Do you have any chronic diseases or conditions? ☐ YES ☐ NO

When was your last visit to a physician? Date: _____

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EMPLOYEE HEALTH HISTORY

Name: _____ **Date:** _____

MEDICAL HISTORY:

Review of systems:

	YES	NO		YES	NO		YES	NO
Alcohol Dependence			Gallbladder trouble			Pneumonia		
Allergy			Glaucoma or cataract			Polio		
Anemia or low blood count			Gonorrhea			Rash or hives		
Asthma			Gout			Rectal bleeding		
Back injury or low back pain			Hay fever			Rheumatic fever		
Bone or joint deformity			Headaches			Rheumatism, arthritis		
Bowel habit change			Head injury			Scarlet fever		
Bone disease			Hearing difficulties			Skin trouble/eczema		
Bursitis or painful shoulder			Heart trouble			Shortness of breath		
Cancer, cyst, growth or tumor			Hemorrhoids (piles)			Sinus trouble		
Chest pain			Hepatitis/jaundice			Swelling of feet/ankles		
Chills, fever, night sweats			Hernia			Swollen/painful joints		
Chronic cough			High Blood Pressure			Syphilis		
Convulsions, epilepsy			Hoarseness			Thyroid disease/goiter		
Coughing or vomiting blood			Indigestion			Tropical disease		
Diabetes			Insomnia			Tuberculosis		
Drug Dependence			Kidney/bladder trouble			Varicose veins		
Ear, nose, throat trouble			Latex Allergy			Varicella (chicken pox/shingles)		
Eye injury or visual problem (including Color Blindness)			Malaria			Worry or depression		
Fainting spells or dizziness			Mental illness			Other:		
Foot trouble			Migraine headaches			Other:		
Fractures			Pleurisy			Other		

Other: _____

Have you ever had or do you now have any of the following)? (Check yes or no)

Have you ever made a claim for compensation? ☐ YES ☐ NO

If yes, for what? _____ Was it settled? _____

Have you ever been rejected from military service for medical reasons? ☐ YES ☐ NO

Are there any situations or illnesses not covered in the above review? ☐ YES ☐ NO

Do you have any limitations or health problems not previously mentioned? ☐ YES ☐ NO

Are you currently under the care of a physician? ☐ YES ☐ NO

Have you traveled outside the United States within the past year? ☐ YES ☐ NO

Do you currently have any communicable diseases? ☐ YES ☐ NO

Have you ever been hospitalized? ☐ YES ☐ NO

1. Operations (and dates): _____
2. Injuries (and dates): _____
3. Illnesses (and dates): _____

I hereby certify that these responses are correct and that I am free from any health impairment which might place patients or others at risk, or which might interfere with the performance of my duties as an employee or volunteer of Stony Brook Eastern Long Island Hospital.

X _____

Signature **Date**

Reviewed by: _____ Complete ☐ Incomplete ☐

Comments: _____