**Stony Brook Eastern Long Island Hospital Health Assessment for Volunteer Applicants**

**Name: Date: Department:**

Please answer the following questions:

1. Have you had any illness, injury, or surgery (other than a simple cold, etc.) lasting longer than 3 days? [ ]  YES [ ]  NO
2. Have you developed any allergies and/or sensitivities to any medications, food, LATEX, plants or chemicals? [ ]  YES [ ]  NO

If yes, please specify substance and reaction.

1. Have you had any major changes in your health as it relates to cardiac or pulmonary function? [ ]  YES [ ]  NO
2. Are you presently taking any medication? [ ]  YES [ ]  NO
3. Have you experienced a significant (25 lbs.) weight gain/loss within the last 12 months? [ ]  YES [ ]  NO

If you answered YES to any of the above, please explain:

1. Have you had a flu vaccine since your annual employee health assessment? [ ]  YES [ ]  NO

If YES, please provide documentation of influenza vaccine. If NO, would you like to have a flu vaccination at this time?

1. Have you had the Tdap booster? [ ]  YES [ ]  NO

If YES, please provide documentation

1. When was your last visit to a physician? Date:

Have you experienced any of the following since your last assessment?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   | **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 |   |   |

**\*** If you answered **YES** to any of the above, please explain:

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.

**Signature** **Date:**

Reviewed by:

Complete [ ]  Incomplete [ ]

Comments: