ENTRANCE EXAMINATION FORM

Conemaugh Health System

Name	**Date of Examination**
Social Security #	**Date of birth**
Address	**Home phone**
Hospitalization Insurance (name and number) **Emergency Contact Information**	**School Attending**

Past Medical History

Date / Age	Medical Problem/Issue

Surgeries/Hospitalizations

Date/Age	Procedure

Current Medications [attach additional pages if needed]

Name	Dose	Diagnosis	Prescribed by

Allergies	

Primary Care Provider _____

Specialist(s) _____

Have you ever been injured at work? ☐ **Yes** ☐ **No**

Conemaugh Employee Health Office

Name _____ Date _____

If yes, please describe:

Latex Allergy Questionnaire

Risk Factor Assessment:

Exposure History:	Yes	No
Do you wear latex gloves regularly or are you otherwise exposed to latex regularly?	❑	❑
Do you have a history of eczema or other rashes on your hands?	❑	❑
Do you have a medical history of frequent surgeries or invasive medical procedures?	❑	❑
Did these take place when you were an infant?	❑	❑
Do you have a history of "hay fever" or other common allergies?	❑	❑

Check any foods below that cause hives, itching of the lips or throat, or more severe symptoms when you eat or handle them:

❑ avocado	❑ apple	❑ pear	❑ celery	❑ carrot	❑ hazelnut
❑ kiwi	❑ papaya	❑ pineapple	❑ peach	❑ cherry	❑ plum
❑ apricot	❑ banana	❑ melon	❑ chestnut	❑ nectarine	❑ grape
❑ fig	❑ potatoes	❑ tomatoes	❑ passion fruit		

II. Contact Dermatitis Assessment:

	Yes	No
Do you have rash, itching, cracking, chapping, scaling, or weeping of the skin from latex glove use?	❑	❑
Have these symptoms recently changed or worsened?	❑	❑
Have you used different brands of latex gloves?	❑	❑
If so, have your symptoms persisted:	❑	❑
Have you used non-latex gloves?	❑	❑
If so, have you had the same or similar symptoms as with latex gloves?	❑	❑
Do these symptoms persist when you stop wearing all gloves?	❑	❑

I. Contact Urticaria (Hives) Assessment:

	Yes	No
When you wear or are around others wearing latex gloves do you get hives, red itchy swollen hands within 30 minutes or, "water blisters" on your hands within a day?	❑	❑

II. Aerosol Reaction Assessment:

When you wear or are around others wearing latex gloves, have you noted any:	Yes	No
Itchy, red eyes, sneezing, runny or stuffy nose, itching of the nose or palate:	❑	❑
Shortness of breath, wheezing, chest tightness or difficulty breathing?	❑	❑
Other acute reactions, including generalized or severe swelling or shock	❑	❑

III.History of Reactions Suggestive of Latex Allergy:

	Yes	No
Do you have a history of anaphylaxis (severe allergic reaction)?	❑	❑
Have you experienced swelling or difficulty breathing after blowing up a balloon?	❑	❑
Do condoms, diaphragms or latex sexual aids cause itching or swelling?	❑	❑
Do rubber handles, rubber bands or elastic bands or clothing cause any discomfort?	❑	❑

Conemaugh Employee Health Office

Name _____ Date _____

Do you have any or current problem with or impairment of? [Check all that apply]

- ❑ Heart – Heart attack, angina, heart failure
- ❑ High blood pressure
- ❑ Palpitations
- ❑ Stroke
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Wheezing
- ❑ Asthma
- ❑ Chronic bronchitis
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Night sweats
- ❑ Fever, chills
- ❑ Headache

- ❑ Dizziness
- ❑ Numbness or tingling
- ❑ Balance issues
- ❑ Weakness
- ❑ Fatigue
- ❑ Fainting
- ❑ Abdominal Pain
- ❑ Poor appetite
- ❑ Recent weight loss or gain
- ❑ Diarrhea
- ❑ Heartburn/indigestion
- ❑ Difficulty swallowing
- ❑ Neck Pain
- ❑ Back Pain
- ❑ Swelling/pain in joints

- ❑ Arthritis
- ❑ Skin rashes
- ❑ HIV/Aids
- ❑ Hepatitis or jaundice
- ❑ Cancer
- ❑ Diabetes Mellitus
- ❑ Thyroid problems
- ❑ Epilepsy – seizures
- ❑ Panic Attacks
- ❑ Claustrophobia
- ❑ Depression/anxiety
- ❑ Wear a hearing aid
- ❑ Wear glasses or contacts
- ❑ Other:

Do you currently use OR have you previously used a tobacco product?	Do you drink alcohol?	Do you currently, or have you in the past, used illicit (street) drugs? ❑
❑Yes ❑ No	❑Yes ❑ No	Yes ❑ No
Type: ❑ Cigarettes ❑ Cigars ❑ Chewing tobacco Frequency:	If yes, how many drinks per week average?	Describe:
# Years Used:		
Quit Date: _____		

I certify that the above occupational and health history is true and correct to the best of my knowledge. I agree to have any necessary blood work drawn, including prescreening titer testing, if needed.

X _____

Signature

Clinician's Notes:

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
Part A

To the employer: _____ Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. However, certain responses, or patterns of response, may lead the reviewer to request further information, or a medical examination, in order to reach a conclusion regarding the employee's ability to safely use a respirator.

To the employee: Patient ID: _____Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the healthcare professional who will review it.

CAN YOU READ? _____ YES _____ NO

Part A. Section 1. (Mandatory)
Every employee who has been selected to use any type of respirator must provide the following information.

1. Today's Date: _____
2. Your Name: _____
3. Your age (to nearest year): _____
4. Sex: _____ Male _____Female
5. Your height: _____ft. _____in.
6. Your weight: _____lbs
7. Your job title: _____ Job title not in list: _____
8. A phone number where you can be reached at between the hours of 8am-4pm by a healthcare professional who reviews this questionnaire(include the area code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire?
    _____ YES _____ NO
11. Check the type of respirator you will use (you can check more than one category):
    □ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    □ Other type (for example, half or full face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator? _____ YES _____ NO
    If "yes" what type(s)? _____

Part A. Section 2 (Mandatory)
Every employee who has been selected to use any type of respirator
Must answer questions 1 through 9 below.

	YES	NO
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month	□	□
2. Have you ever had any of the following conditions?		
a. Seizures (fits)	□	□
b. Diabetes (sugar disease):	□	□
c. Allergic reactions that interfere with your breathing:	□	□
d. Claustrophobia	□	□
e. Trouble smelling odors	□	□
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis:	□	□
b. Asthma:	□	□
c. Chronic bronchitis:	□	□
d. Emphysema:	□	□
e. Pneumonia:	□	□
f. Tuberculosis:	□	□
g. Silicosis:	□	□
h. Pneumothorax:	□	□
i. Lung cancer:	□	□
j. Broken ribs:	□	□
k. Any chest injuries or surgeries:	□	□
l. Any other lung problem you've been told about:	□	□
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath:	□	□
b. Shortness of breath when walking fast on lever ground or walking up a slight hill or incline:	□	□
c. Shortness of breath when walking with people at an ordinary pace or level ground:	□	□
d. Have to stop for breath when walking at your own pace on level ground:	□	□
e. Shortness of breath when washing or dressing yourself:	□	□
f. Shortness of breath that interferes with your job:	□	□
g. Coughing that produces phlegm (thick sputum):	□	□
h. Coughing that wakes you early in the morning:	□	□
i. Coughing that occurs mostly when you are lying down:	□	□
j. Coughing up blood in the last month:	□	□
k. Wheezing:	□	□
l. Wheezing that interferes with your job:	□	□
m. Chest pain when you breathe deeply:	□	□
n. Any other symptoms that you think may be related to lung problems:	□	□

Part A. Section 2. (Mandatory) (Continued) **YES** **NO**

5. Have you ever had any of the following cardiovascular or heart problems?

a. Heart attack:	□	□
b. Stroke:	□	□
c. Angina:	□	□
d. Heart failure:	□	□
e. Swelling in your legs or feet (not caused by walking):	□	□
f. Heart arrhythmia (heart beating irregularity):	□	□
g. High blood pressure:	□	□
h. Any other heart problems that you've been told about?	□	□

6. Have you ever had any of the following cardiovascular or heart problems?

a. Frequent pain or tightness in your chest:	□	□
b. Pain or tightness in your chest during physical activity:	□	□
c. Pain or tightness in your chest that interferes with your job:	□	□
d. In the past two years, have you noticed your heart skipping or missing a beat:	□	□
e. Heartburn or indigestion that is not related to eating:	□	□
f. Any other symptoms that you think may be related to heart or circulation problems:	□	□

7. Do you currently take medication for ant of the following problems?

a. Breathing or lung problems:	□	□
b. Heart trouble:	□	□
c. Blood pressure:	□	□
d. Seizures (fits):	□	□

8. If you've used a respirator, have you ever had any of the following problems?

a. Eye irritation:	□	□
b. Skin allergies or rashes:	□	□
c. Anxiety:	□	□
d. General weakness or fatigue:		
e. Any other problem that interferes with your use of a respirator:	□	□

9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire? □ □