Heritage Nursing Agency

704 Tuolumne Street, Vallejo CA 94590
Phone Number: (707) 641-1051
Email Address: staffing@heritagenursesvallejo.com

Health Questionnaire

Last name: _____ First: _____ M.I._____ Age: _____ Sex: ___ Date of Birth _____/_____/_____

Address: _____ City: _____ State _____ ZIP _____

Phone No. (_____) _____ - _____ Cellphone No. (_____) _____ - _____

Notify in case of emergency:

Name _____ Relationship: _____ Phone No. (_____) _____ - _____

Do you have a family history of?

Tuberculosis: Yes ☐ No ☐ Nervous or mental illness: Yes ☐ No ☐ Diabetes: Yes ☐ No ☐

Have you had, or do you have any of the following? (Check appropriate box)

Disease of	Yes	No	Disease of	Yes	No	Disease of	Yes	No	Disease of	Yes	No
Brain			Genitals			Chronic Congestion			Malaria		
Eyes			Dizziness			Black or bloody			Rheumatic fever		
Ears			Running ears			bowel movements			Paralysis		
Nose			Palpitations			Frequent Headaches			Cancer or tumors		
Throat			Asthma			Chronic Cough			Freq. Sore throat		
Diabetes			Hay fever			Painful flat feet			Frequent colds		
Stomach			Arthritis			Blood in urine			Intestines		
Chest pains			Jaundice			Swollen ankles			Rheumatism		
Liver			Spleen			Fainting spells			Hernia (rupture)		
Heart			Lungs			High blood pressure			Shortness of breath		
Gallbladder			Pneumonia			Coughing up blood			Stomach Ulcers		
Backaches			Kidneys			Kidney stones			Chronic sinus infection		
Bladder			Allergies			Injuries			Frequent or painful urination		
Bone			Poor Appetite			Fits of convulsions			Operations		
Joints			Tuberculosis			Chronic Indigestion			Vomiting of blood		
Back (spine)			Bronchitis			Recurrent nausea			Other serious illness (list below)		
Skin			Lymph nodes			Recurrent vomiting					

Do you have a hearing problem? Yes ☐ No ☐ What is your weight? _____ Lbs.

Have you ever been rejected or discharged from military service because of illness of injury? Yes ☐ No ☐

If yes, please explain: _____

Have you ever received any pension, insurance payments or compensation for an injury or illness? Yes ☐ No ☐

If yes, please explain: _____

Do you have any defect or deformity which may interfere with your job? _____

State details of illnesses, injuries, operations of defects: _____

Are you currently under the care of a physician? Yes ☐ No ☐

If "Yes", please explain:

_____

_____

_____

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Are you taking medications? Yes ☐ No ☐ If yes, give names and dosages:

_____ _____

_____ _____

Are there are any other problems not already listed? If yes, please explain.

_____ _____

_____ _____

The following is to be completed by Examining Physician or Nurse Practitioner.

Systems Review	**Comments**
Head	_____
Eyes/Ears/Nose/Throat	_____
Nodes	_____
Heart	_____
Lungs	_____
Abdomen	_____
Hernias	_____
Back	_____
Skin	_____
Gait/Posture/Squat	_____
ROM	_____
Extremities	_____

Vital Signs: BP: _____/_____ P: R: T: Height Weight:

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Name: _____ Date ____/____/_____

Tuberculosis (TB) Screening and Testing Questionnaire

1. How old are you? _____

2. Have you ever had a vaccine to prevent tuberculosis (BCG vaccine)? (Usually given as infant or child. You may have scar on your arm for the vaccine) Yes ☐ No ☐

3. Have you ever had a Tuberculosis (skin) test? Yes ☐ No ☐
If "Yes", did the area become red or swollen? Yes ☐ No ☐

4. Have you ever had a positive/reactive TB skin test? Yes ☐ Date: _____ No ☐

5. Have you even been told you have TB? Yes ☐ Date: _____ No ☐

6. Have you ever been treated for either active or latent TB? Yes ☐ Date: _____ No ☐

7. Have you ever had a chest X-RAY which showed tuberculosis? Yes ☐ Date: _____ No ☐

8. Do you have any chronic illnesses (for example: diabetes, asthma, ulcerative, colitis, Crohn's disease, rheumatoid arthritis, lupus, leukemia, lymphoma, chronic renal failure)? **Please circle the illnesses** Yes ☐ No ☐

9. Have you ever diagnosed with or treated for cancer? Yes ☐ No ☐

10. Have you ever been diagnosed with AIDS, tested positive for HIV, used illegal injectable drugs, or shared needles with anyone? Yes ☐ No ☐

11. Do you take any medications that make your immune system weak such as TNF-alpha blocker (ENBREL, Remicade) or steroids (prednisone >15 mg per day for > 1 month)? Yes ☐ No ☐
List the medications here: _____

12. Were you born, or have you lived in a country that has a high incidence of active tuberculosis disease? Yes ☐ No ☐
(see list provided) **Please write the county name(s):** _____

13. What countries have you traveled to in the last 2 years? Yes ☐ No ☐
Please write the county name(s) _____

14. Have you ever lived with someone known or suspected to have active TB? Yes ☐ No ☐

15. Have you received any of these live vaccinations in the past 4 weeks? Yes ☐ No ☐
Flumist, MMR, Oral Typhoid, Varicella (Chicken Pox), Yellow fever **(Circle the vaccines)**

16. Do you have allergies to latex, medications, or any vaccine? Yes ☐ No ☐
List the allergies here: _____

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17. Have you ever lost your balance or fainted from having blood drawn? Yes ☐ No ☐
18. Do you have any of the following symptoms that are sometimes symptoms of tuberculosis:

- Chest Pain Yes ☐ No ☐
- Cough that has lasted for 3 weeks or longer Yes ☐ No ☐
- Coughing up blood Yes ☐ No ☐
- Fever Yes ☐ No ☐
- Loss of appetite Yes ☐ No ☐
- Night sweats Yes ☐ No ☐
- Unexplained weight loss Yes ☐ No ☐

P.P.D. Test

Warning: Tuberculosis skin tests should not be given to known tuberculin-positive reactors. If a history of positive skin test(s) exists, the employee needs a negative chest x-ray.

Name _____ Lot # _____

Date Given ____/____/_____ Site _____

Date Read ____/____/_____ Exp. Date ___/___/_____

Size _____ mm (If no induration, indicate "0" mm.)

Name/Title _____ **Date:** ___/___/_____

If induration is 10mm or greater, then a chest x-ray indicating no active T.B. is required.

I, the undersigned, certify that the above answers are true, and I give permission to release a copy of this physical examination & TB/X-Ray report to my agency and to the contracted facilities.

Printed Name: _____ **Signed:** _____ **Date:** _____

Final Disposition & Certification

PASS ☐ **I have examined the individual named above and to the best of my knowledge, he/she is in good physical and mental health and is able to function in his/her profession in full capacity.**

FAIL ☐ **I have examined the individual named above and the best of my knowledge, he/she is not in good physical and/or mental health and is not able to function in his/her profession in full capacity.**

Medical Examiner's Signature: _____ **Title:** _____ **Date** _____

Medical Examiner's Name (PRINT) _____

Address: _____ **City:** _____ **State:** _____ **ZIP** _____

Telephone Number: _____