ALASKA REGIONAL HOSPITAL

EMPLOYMENT MEDICAL RECORD

Name (Last, First, MI)	Social Security Number	Date of Birth	Position	Date Prepared

Home Address	Phone Number

When an injury is caused or aggravated by one of the physical conditions listed below, the employer may apply for reimbursement of cost. Please indicate by a check mark if you have been afflicted by any of these conditions:

☐ Amputated:leg/foot/arm/hand	☐ Color Blindness	☐ Multiple Sclerosis	☐ Thrombophlebitis
☐ Arteriosclerosis	☐ Diabetes	☐ Muscle weakness/paralysis/ numbness	☐ Trick/Dislocated: shoulder/ elbow/wrist/knee
☐ Arthritis	☐ Dizziness	☐ Muscular Dystrophy	☐ Tuberculosis
☐ Blood disorder	☐ Hearing Loss	☐ Parkinson's Disease	☐ Varicose Veins
☐ Bone disease	☐ Heart Disease	☐ Polio	☐ Weakness/fatigue/shortness of breath
☐ Cerebral Palsy	☐ High Blood Pressure	☐ Pulmonary Diseases	☐ OTHER:
☐ Cerebral Vascular Accident (Stroke)	☐ Loss of Sight	☐ Seizures	
☐ Chronic osteomyelitis	☐ Low Blood Sugar	☐ Silicosis/Abestosis	
	☐ Mental Illness		

ALLERGIES OR SENSITIVITIES

Medication Allergies:

Latex Allergies or Sensitivities:

Other Allergies Or Sensitivities:

MEDICATIONS

Please List Any Medications You Are Currently Taking:

☐ NONE

List any previous illnesses or injuries to the following:

		Work Related?	DATE	DESCRIPTION	Any Remaining Restrictions?
HEAD & NECK	☐ Injury ☐ Illness	☐ Yes ☐ No			☐Yes ☐No
BACK	☐ Injury ☐ Illness	☐ Yes ☐ No			☐Yes ☐No
ARMS & LEGS	☐ Injury ☐ Illness	☐ Yes ☐ No			☐Yes ☐No
OTHER PARTS OF THE BODY	☐ Injury ☐ Illness	☐ Yes ☐ No			☐Yes ☐No

Please Answer The Following Questions:

WHEN DID YOU LAST SEE A PHYSICIAN?	REASON:
HAVE YOU EVER BEEN ADVISED TO HAVE ANY SURGICAL PROCEDURE? ☐ Yes ☐ No	IF YES, DESCRIBE AND GIVE AGE AT WHICH OCCURRED:
Have you sought medical treatment for any injury or illness which resulted in hospital confinement that has yet to be mentioned? ☐ Yes ☐ No	IF YES, DESCRIBE:
CHECK ANY OF THE FOLLOWING AROUND WHICH YOU HAVE WORKED: ☐ CHEMOTHERAPY ☐ HAZARDOUS CHEMICALS ☐ RADIATION	IF CHECKED, PLEASE SPECIFY WHERE AND WHEN:

DO YOU SMOKE? ☐ Yes ☐ No	If Yes, how much?	For how many years?

Dates Of Immunization And Screening:

Measles/Mumps/Rubella (MMR)	Measles, MR or MMR#2 (If born during or after 1957)	Hepatitis A series	Hepatitis B series

Have you ever had chicken pox? ☐Yes ☐No ☐Unsure (If no or unsure, we will order a titer to test for immunity)	Date of last TB skin test:	Have you ever had a positive TB skin test? ☐Yes ☐No If yes, date of last Chest X-ray?	Have you had BCG vaccine? (**Not** routine in USA) ☐Yes ☐No *(Per CDC guidelines, BCG vaccination is not a contraindication for tuberculin skin testing. Tuberculin skin testing should be done regardless of history of BCG vaccination)*

Please Complete Next Page

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Do you feel you have any other conditions that would influence your ability to perform the job you are taking? ☐ Yes ☐ No

If Yes, Please describe or explain:

I have completed the foregoing statements of my medical history and I understand that any false statements or information purposely omitted will be sufficient cause for termination or reduction of Worker's Compensation benefits.

EMPLOYEE SIGNATURE:	DATE:

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TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT PERSONNEL

Comments:

SCREENING OR IMMUNIZATIONS ORDERED

☐ TB Skin test	☐ MMR
☐ 2nd TB Skin test 1 – 3 weeks later	☐ Rubella titer
☐ CXR	☐ Rubeola titer
☐ TB Clinic Evaluation	☐ Varicella titer

☐ *NO PROBLEMS NOTED AT PRESENT FOR POSITION ACCORDING TO DATA PROVIDED*

SIGNATURE HR PERSONNEL COMPLETING EVALUATION
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