UVA WorkMed Screening Form E Mail: ____

1910 Arlington Blvd.
Charlottesville, VA 22903
Phone: 434-243-0075 Fax: 434-243-0078

MRN# ______________________ Employee ID# _____________________

Name: ____ Birth Date:___________________

Last *First* *Middle/Maiden*

Job Title:_____ ______________________________ Dept.: ____

Home Address _______________________________ City/State/Zip _____________________________________

Home Phone _________________________________Mobile Phone __________________________________

1. Have you had **chickenpox**? Please circle one: **YES** **NO** **UNKNOWN**
   If no, have you had Varicella (chickenpox) vaccine? ………………………………………...................YES NO
   If yes, you must provide medical documentation.
2. Have you had a rubella antibody test (**German Measles**)? ……………………………….................YES NO
   If yes, you must provide documentation of result.
3. Have you had measles**, mumps and/or rubella vaccine**? ……………………………………...........YES NO
   If yes, you must provide medical documentation.
4. Have you had the **tetanus** series? ……………………………………………………………………..YES NO
   If yes, you must provide medical documentation.
5. Have you had **tetanus, diphtheria and acelluar pertussis (whooping cough) Tdap** vaccine? ……………YES NO
   If yes, provide medical documentation.
6. Have you had a **reaction (redness and swelling) to a tuberculin skin test**...................................YES NO
7. Have you ever been diagnosed with or suspected of having **tuberculosis**?. ....YES NO
8. Have you ever received treatment for latent tuberculosis (i.e. INH therapy)?. ....YES NO
   If yes, please give treatment dates_______________________________
9. Have you had the **Hepatitis B vaccination series**? ………………………………………................YES NO
   If yes, you must provide medical documentation.
   If yes, did you have an antibody test drawn approximately one to two months after your 3rd injection?...YES NO
   If yes, you must provide documentation of results.
10. Have you ever been diagnosed with or suspected of having **HIV**? ....YES NO
11. Have you ever been diagnosed with **yellow jaundice/hepatitis**? When?_________________ ....YES NO
12. Have you ever been told you have **liver disease**? ....YES NO
13. Have you ever been diagnosed with a **reportable infectious disease that might pose a risk to patients you will be caring for during your job functions**? ....YES NO
14. Are you currently infected or colonized with methicillin-resistant *Staph aureus* (**MRSA**).......................YES NO

OVER -→

15. Are you currently infected or colonized with vancomycin-resistant enterococcus (**VRE**) ....YES NO
16. Have you had a **seizure** in the past six-months?..YES NO
17. Have you been told by a physician that you have an **allergy to latex**? ....YES NO
18. Do you have trouble identifying colors?..YES NO
19. Do you smoke? Yes ____No____ If yes, how many packs per day? _______________
20. Do you consume alcoholic beverages? Yes ____ No ____ If yes, how many drinks per week ? ________
21. Do you currently use drugs such as marijuana, cocaine, or other similar or illegal drugs? Yes ____No____
22. Do you have a disability? No _____ Yes _____ If yes, explain:____
____
23. Have you had any surgeries and/or hospitalizations? No ____ Yes _____ If yes, explain: _____________________
____
____
24. Do you have allergies? No _____ Yes _____ If yes, please list:____
25. Current medications (prescription and over the counter): ____
____
____
26. Please put a CHECK next to any of the following condition(s) that apply to you.

Condition		Condition		Condition	
(1) Hearing Loss		(10) Poor Circulation		(19) Headaches	
(2) Vision Disorder		(11) Stomach Disorders		(20) Head Injury	
(3) Chronic Cough		(12) Tumors/Cancer		(21) Skin Disease	
(4) Breathing Disorder		(13) Arthritis		(22) Kidney/Urinary Disorder	
(5) Heart Attack		(14) Muscle Disorder		(23) Liver Disorder	
(6) Heart Failure		(15) Back Disorder		(24) Anxiety	
(7) Heart Pain		(16) Loss/Limited Use of Extremity		(25) Nervous Breakdown	
(8) Heart Valve Disorder		(17) Shoulder Problems		(26) Tuberculosis	
(9) High Blood Pressure		(18) Seizures			

For above areas CHECKED or answered YES, please list number and explain: ___________________________________
____
____
____

The purpose of this information is to establish a medical history. This is retained by UVA-WorkMed and becomes part of your medical record.

Signature: ____ Date: _____________________

Reviewed by:____ Date:_____________________