MONUMENT HEALTH

☐ Transfer ☐ Previous Employee ☐ Scanned ☐ OHM

Employee Health - Health History Screen

Please answer the following questions carefully and completely. Your answers will be treated with strict confidence and will be maintained as part of your Employee Health medical record. Only information regarding specific work restrictions will be shared with your supervisor. If you omit or misrepresent the information requested, it may/can result in dismissal when discovered.

MARKET ☐ Custer ☐ Lead-Deadwood ☐ Rapid City ☐ Spearfish ☐ Sturgis			
LAST NAME (print)	LEGAL FIRST NAME		MIDDLE NAME
PREVIOUS NAME	SOCIAL SECURITY #		
STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE #	EMPLOYMENT DATE	DEPARTMENT/JOB TITLES	
DATE OF BIRTH	AGE	SEX ☐ Male ☐ Female ☐ Other: _____	

Have you been in contact with someone who was sick in the past two weeks? ☐ Yes ☐ No ☐ Unsure

Do you have any of the following symptoms?

☐ Stomach Pain ☐ Bruising or Bleeding ☐ Cough ☐ Diarrhea ☐ Fever ☐ Joint Pain ☐ Muscle Pain

☐ Rash ☐ Red Eye ☐ Severe Headache ☐ Vomiting ☐ Weakness ☐ None of these ☐ Unsure

Have you traveled internationally in the last month? ☐ Yes ☐ No ☐ Unsure

If yes, Location: _____

Are you taking any prescribed medications that would interfere with your ability to safely perform your job?

☐ Yes ☐ No

If yes, list the medications: _____

_____

_____

Allergies: ☐ Yes ☐ No If Yes, list: _____

Known or suspected latex allergy? ☐ Yes ☐ No If Yes, list: _____

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Monument Health requires all healthcare personnel to have baseline TB Screening, including an individual risk assessment and symptom screen which is necessary for interpreting any test result.

To complete the Risk assessment please answer the following questions as recommended by the Centers for Disease Control (CDC).

Have you been a temporary or permanent resident (one month or more) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States and those in western or northern Europe)?
☐ Yes ☐ No

Have you had known close contact with someone who has had infectious TB since your last TB test? ☐ Yes ☐ No

Are you currently experiencing or planning immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with TFN-alpha antagonist (e.g., infliximab, etanercept, or other) chronic steroids (equivalent of prednisone greater than or equal to 15 mg/day for greater than or equal to 1 month) or other immunosuppressive medication? ☐ Yes ☐ No

Have you had a cough that lasted longer than 2 weeks? ☐ Yes ☐ No

Have you had pain in your chest? ☐ Yes ☐ No

Have you coughed up blood or bloody sputum? ☐ Yes ☐ No

Have you had weakness or fatigue? ☐ Yes ☐ No

Have you had unexplained weight loss? ☐ Yes ☐ No

Have you had loss of appetite? ☐ Yes ☐ No

Have you had fever, chills or sweating at night? ☐ Yes ☐ No

If you answered yes to any of the above questions please explain:

_____

_____

_____

Abbreviation: TNF = tumor necrosis factor.

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SOUTH DAKOTA DEPARTMENT OF HEALTH - Article 44:75:04:06 requires that:

"The facility must have an employee health program for the protection of the patients or residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties requiring care of patients or residents or within 14 days after employment, including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease during the period of communicability to work in a capacity that would allow spread of disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of patients and fellow employees may not return to duty until they are determined by a provider, provider's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage."

All information in this questionnaire will be dealt with confidentially and maintained in a separate medical file in accordance with federal law. The Licensed Health Care Professional will have access to your health file. The information you give may be of considerable help to the Licensed Health Care Professional as he/she seeks to help you protect your future health.

Are you currently being treated for any of the following reportable diseases, or a reportable communicable disease not listed?

Hepatitis A, B, C	☐ Yes	☐ No	Human Immunodeficiency Virus	☐ Yes	☐ No
Skin Rashes/Eczema	☐ Yes	☐ No	Measles	☐ Yes	☐ No
Diarrheal disease	☐ Yes	☐ No	Chickenpox	☐ Yes	☐ No
Influenza	☐ Yes	☐ No	Mumps	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Pertussis	☐ Yes	☐ No
Rubella	☐ Yes	☐ No	Scabies	☐ Yes	☐ No
Conjunctivitis	☐ Yes	☐ No	Group A Strep	☐ Yes	☐ No
Staph aureus	☐ Yes	☐ No			
Other	☐ Yes	☐ No	If yes, explain: _____		

If you have given a "yes" answer and are currently being treated for any of the items above, you are required to provide documentation from your attending physician to the Licensed Health Care Professional indicating the stage of or absence of communicability prior to reporting to your work assignment. Our facility will pay for costs incurred to determine the presence or absence of communicable state; however, we will not assume costs for any treatment. If there is a current state of communicability, you may not report to work until your attending physician has released you from a communicable stage.

According to the above information, this employee appears to be free of communicable disease.

Licensed Health Care Professional: _____ **Date:** _____

CERTIFICATION AND RELEASE (please complete and sign)

I certify that the foregoing statements are true and correct to the best of my knowledge. I understand that this inquiry, and physical examination if applicable, are made solely in connection with work requirements and do not constitute a complete and comprehensive medical examination. I further understand that this inquiry, and examination if applicable, does not involve a customary doctor-patient relationship.

Printed Name: _____

Signature: _____ **Date:** _____ **Time:** _____

Licensed Health Care Professional Signature: _____ **Date:** _____ **Time:** _____

NOTICE

As of July 1, 1994, the notice provision of South Dakota's Worker's Compensation Act (SDCL 62-7-10) requires employees to provide notice of all injuries for which they intend to claim the right to Worker's Compensation benefits no later than THREE (3) business days after the injury occurred. Failure to provide notice could prohibit compensation for a claim.

I acknowledge receipt of this notification:

Signature: _____ **Date:** _____ **Time:** _____