KAISER PERMANENTE

Kaiser On-the-Job®

Occupational Health and Safety
HEALTH HISTORY and PREPLACEMENT QUESTIONNAIRE

Name: _____ Sex: ☐ Male ☐ Female Date of Birth_____

Home Address: _____ City _____ Zip_____

Home Telephone: _____ Social Security # _____

Company_____Job Title: _____Department: _____

Company Phone:_____Fax: _____Hire Date:_____

INTRODUCTION

The information you provide in this questionnaire is extremely important. It will be used by a physician or health care professional to advise your employer of your ability to perform the essential functions of the job safely without endangering yourself or others. Please fill out the questionnaire completely and accurately.

Please answer all questions completely. Do not leave any answers blank; use either "NA" (not applicable) or "Don't Know."

MEDICATIONS

1. Are you taking any medications (prescription or non-prescription) which affect your balance, awareness, hearing, sight, or ability to walk, stand, sit, lift, bend or reach?

   YES ☐ NO ☐.

If your answer is "YES," provide the following information below:

(1) Type of medication _____
(2) Specific work limitation(s) _____
_____

(3) Type of job accommodation(s) requested (if any) _____
_____

2. Have you undergone any operations, surgeries or hospitalizations that limit your current ability to perform the essential physical or mental duties of your position? Yes ____ No ____

If your answer is "YES," provide the following information:

(1) Date of procedure/hospitalization _____
(2) Specific work limitation(s) _____
(3) Type of job accommodation(s) requested _____

3. Has a physician restricted you from currently performing any physical or mental activities that necessary to perform your essential job duties/functions as identified in the attached job description? Yes ☐ No ☐ If your answer is "YES", provide the following information:

Date Restriction Given	Name of Physician	Restriction

4. Do you require any work-related accommodation for a mental or physical condition (including for example, but not limited to: vision or hearing impairment, allergies, skin condition, dizziness/fainting/loss of consciousness, convulsions/seizures/epilepsy, breathing problems, diabetes, headaches, musculoskeletal problems, psychological or emotional disorders, drug/alcohol treatment) to be able to perform the essential duties/functions of your job as identified in the attached job description? Yes ☐ No ☐

If your answer is "YES" to number 4, please provide the following information below:

(1) Specific work limitation(s) _____
(2) Type of job accommodation(s) requested _____
_____

5. Do you currently experience any chronic pain or musculoskeletal problems (for example: pain, tingling, numbness, limited motion, limitation in walking, standing, sitting, bending, lifting, reaching, etc.) which limit your ability to perform the essential duties/functions of your job as identified in the attached description? Yes ☐_ No ☐.

If your answer is "YES," circle below the body part(s) affected:

Neck Shoulder Ankle Wrist Hand

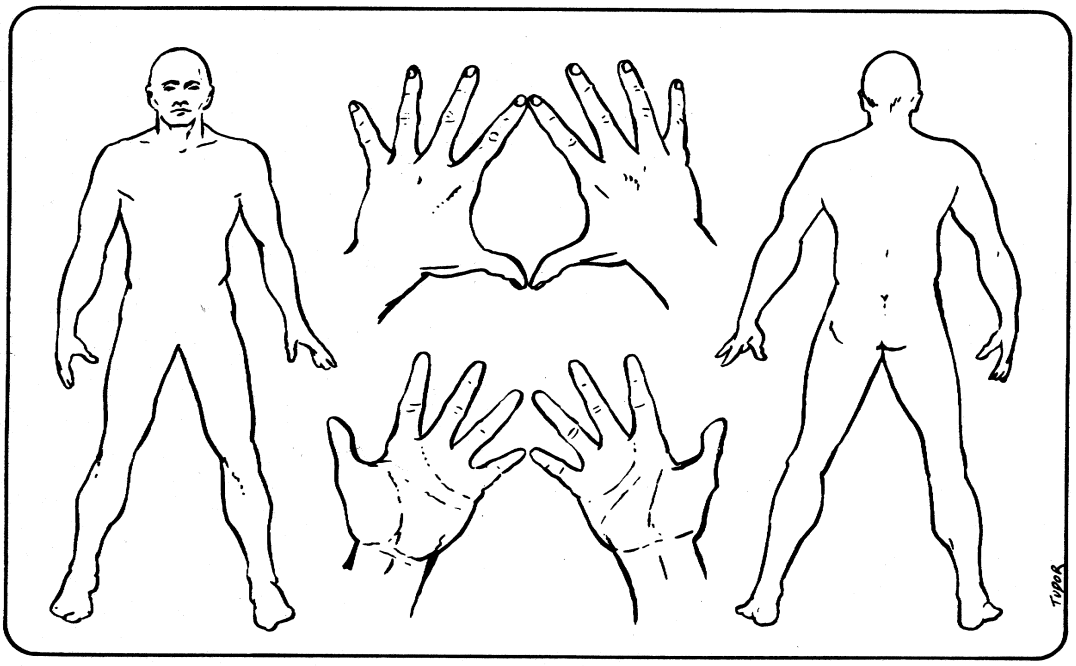
Back Hip Knee Elbow Foot

In addition, please indicate any limitations created by your condition: _____

6. Please mark on the diagrams below where you currently experience pain, tingling or numbness or other problems identified in response to Question 5
:

PAIN == xxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxx

TINGLING or NUMBNESS == ••••••••••••••••••• ••••••••••••••••••• •••••••••••••••



ENVIRONMENTAL HISTORY

Please answer the following questions ONLY if your job requires that: (1) you work in an environment where you are likely to come into contact with chemicals or substances (e.g., latex, radiation, lead, paints, glues, dust, etc.); or (2) you use protective gear or equipment. (If neither of these requirements applies to your job, answer "N/A" below and proceed to the "Employee Certification" section.)

7. Do you have an allergy and/or sensitivity (e.g. irritation to eyes or skin, difficulty breathing) to latex, chemicals or other environmental substances that limits your current ability to perform the essential duties/functions of your position as identified in the attached job description?

(1). Allergy/Sensitivity Yes☐ No☐
(2). Chemical(s) or substance(s) Yes☐ No☐
(3). Specific work limitation(s)_____

(4). Type(s) of job accommodation(s) requested_____

8. From the list provided below, identify the personal or protective gear/equipment that you will be required to use in your position and describe any work restriction or limitation that you have with regard to the use of the protective gear/equipment.

Respirator? Yes ☐ No☐

Specific work limitation(s):_____

Hearing Protection ? Yes☐ No☐

Specific work limitation(s):_____

Gloves? Yes☐ No☐

Specific work limitation(s):_____

Protective Clothing? Yes☐ No☐

Specific work limitation(s):_____

Safety glasses/goggles? Yes ☐ No☐

Specific work limitation(s):_____

Other gear/equipment? Yes☐ No☐

Specific work limitation(s):_____

9. Are you currently receiving medical treatment because of an exposure to a chemical or biological substance? Yes☐ No☐
If your answer is "YES", identify the chemical or biological substance and any work-related restriction/ limitation below:

(1). Chemical or Biological Substance(s): _____

(2). Specific work limitation(s): _____

(3). Type(s) of job accommodation(s) requested:_____

10. Have you ever worked with any of the following? (check all that apply)

☐ Asbestos ☐ Lead ☐Radiation
☐ Dust ☐ Noise ☐ Silica Powder
☐ Latex ☐ Pesticides ☐ Solvents
☐ Lasers ☐ Paints and glues ☐Other chemicals
☐ Substances which irritated your skin or eyes
☐ Substances which caused you breathing difficulties

I hereby certify that all of my statements and answers are true and complete, and I understand that any misstatement of material fact may subject me to disqualification or dismissal and may cause forfeiture of all rights to employment.

Signature in full: _____ Date:_____

Reviewer:_____ Date:_____

Clinician Comments:

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