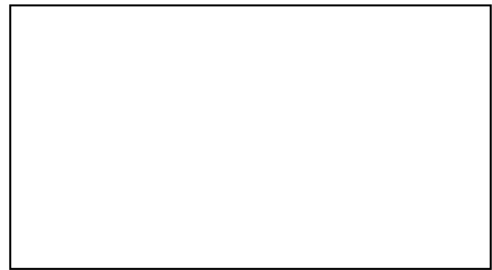
KAISER PERMANENTE

Kaiser on the Job



Pre-Placement Health Questionnaire

Name: ______________________________ Sex: ☐ Male ☐ Female Date of Birth________

Home Address: _________________________________ City ____________ Zip__________

Home Telephone: _______________ Fax: _____________

Social Security # ___________Job Title: _______________Department: _____

Hire Date: ________

Instructions

The information you provide in this questionnaire will be used by your employer to: (1) determine if you are immunized against communicable diseases, and (2) evaluate your ability to perform the essential functions of the job, with or without accommodation, and without endangering yourself or others.

You are required to answer all of the questions on this form, except where indicated otherwise, as a condition of employment. The employer's designated physician or health care professional will review your answers and you may be asked to provide additional information concerning your health status or history. You may also be referred to a physician for further assessment and treatment prior to being cleared by Employee Health to start working. In the event information you provide would disqualify you from employment, you may submit independent medical opinions for consideration by the employer before a final determination on disqualification is made. The information you provide will be kept confidential, except that appropriate managers may be notified of any work-related restrictions and/or accommodations you may be given to enable you to perform the essential functions of your position.

Please answer all questions completely and accurately. If the question does not apply to you, enter "N/A" or "Not Applicable". If you do not know the answer to the question, enter "Don't know".

Current Job Limitations

Before answering the following questions, please review the attached job description for a list of all essential job duties, including physical and mental functions, specific to your position.

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 to 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**

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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__________________________
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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: ____________________

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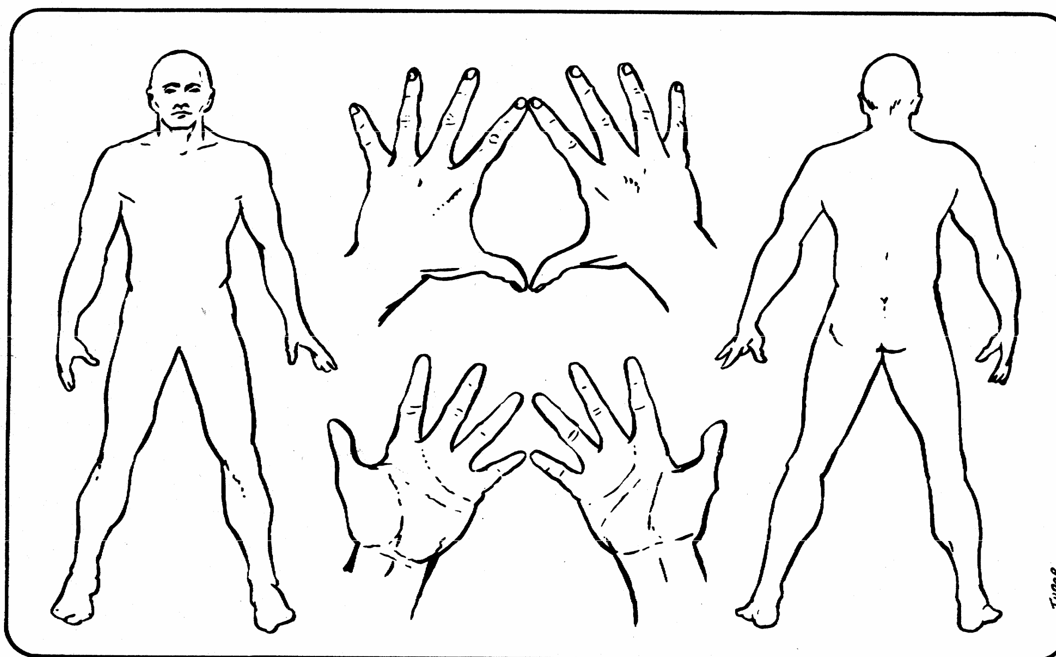
6. Please mark on the diagrams below where you currently experience pain, tingling or numbness or other problems identified in response to Question 5:

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 apply 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

Employee Certification

I hereby certify that I have reviewed and understand the questions on this form, and that all of my statements and answers to the questions set forth above are true and complete. I understand that any false statement or omission of material fact may subject me to disqualification or dismissal and may cause forfeiture of all rights to employment.

Employee Signature: ________________________Date:_________

Health Care Provider Review and Signature
Reviewer Comments:

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Reviewer Signature:______________________ Date:__________________