Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

EMPLOYEE PRE-PLACEMENT HEALTH QUESTIONNAIRE
STRICTLY PERSONAL AND CONFIDENTIAL

Last Name First Name		Date of birth Year | Month | Day
Current home address Number Street Apt./Unit City Province/Territory Postal code		Gender Telephone number
Department	[ ] Full-time [ ] Part-time	Social insurance number
Position	Shifts to be worked	Health card number

Family Physician

Name Clinic Number Street Unit/Suite

City Province/Territory Postal code Telephone number

In case of emergency, please notify…

First name Last name Relationship Telephone number

The personal health information disclosed on this form and/or collected during the pre-placement health assessment will be kept strictly confidential and maintained in your Medical Record within the Occupational Health Department at Kingston Health Sciences Centre. All personal health information collected during the pre-placement assessment, and anytime thereafter, is strictly confidential and will not be disclosed or released outside of the Occupational Health Department without your written consent. From time to time certain non-medical, personal information may need to be shared with individuals (e.g. your Manager, Human Resources). It will be limited to the following:

1. Information pertaining to fitness to work and required accommodation to ensure a safe return to work or accommodation in the workplace.
2. Acknowledgement that the employee has contacted Occupational Health and/or supplied documentation if required to do so.
3. Administrative data related to sick benefits (e.g. claim status).

I the undersigned have read and understood the above. I have had the opportunity to ask any questions to clarify any parts of the above which have been unclear to me. I also understand that certain disclosures that are required by health care professionals (such as releasing information that may be required to avert or address a health or safety risk to me or others, or as required by law such as reporting to the Workplace Safety Insurance Board) do not require my consent.

Date Year | Month | Day	**Signature of applicant**
Date Year | Month | Day	**Occupational Health Nurse**

PERSONAL MEDICAL HISTORY

Do you have, or have you ever had, any of the following? Please check the appropriate response to all the questions.

	No	Yes
Allergies/Sensitivities		
Drug(s)	[ ]	[ ]
Food(s)	[ ]	[ ]
Chemical(s)/Perfume	[ ]	[ ]
Latex	[ ]	[ ]
Bee stings	[ ]	[ ]
Molds, dust, other	[ ]	[ ]
Skin Disorders		
Eczema/dermatitis/ psoriasis, other	[ ]	[ ]
Psychological		
Anxiety disorder, Depression, Schizophrenia, Bipolar, other	[ ]	[ ]
Neurological		
Seizures	[ ]	[ ]
Headaches /Migraines	[ ]	[ ]
Brain injury/concussion	[ ]	[ ]
Sleep disorder	[ ]	[ ]
Neurologic disorders (e.g., numbness, weakness, multiple sclerosis, muscular dystrophy)	[ ]	[ ]

	No	Yes
Eyes/Ears/Nose/Throat		
Eye/visual problems	[ ]	[ ]
Hearing/ear problems	[ ]	[ ]
Cardiovascular		
High blood pressure	[ ]	[ ]
Heart Murmur/ palpitations	[ ]	[ ]
Angina/ heart attack	[ ]	[ ]
Respiratory		
Lung disease (e.g., asthma, bronchitis, emphysema, TB)	[ ]	[ ]
Endocrine/Metabolic		
Diabetes	[ ]	[ ]
High cholesterol	[ ]	[ ]
Thyroid disease	[ ]	[ ]
Digestive System		
GI disorders (e.g., Crohn's, Ulcers)	[ ]	[ ]
Liver disease (e.g., hepatitis B or C)	[ ]	[ ]

	No	Yes
Musculoskeletal		
Muscle, tendon, or bone disorder	[ ]	[ ]
Hernia: inguinal or abdominal	[ ]	[ ]
Back problems (e.g., pain, disc herniation, disc disease)	[ ]	[ ]
Overuse/repetitive strain injury (e.g., tendonitis, carpal tunnel)	[ ]	[ ]
Arthritis/joint disease	[ ]	[ ]
Fractures	[ ]	[ ]
Amputations (partial or total)	[ ]	[ ]
Blood		
Blood disorders, Anemia	[ ]	[ ]
Infectious Diseases		
Pneumonia/HIV/AIDS or other	[ ]	[ ]
Other		
Chronic pain	[ ]	[ ]
Cancer	[ ]	[ ]
Addictive Illness- Drug, Alcohol	[ ]	[ ]
Fibromyalgia	[ ]	[ ]
Learning Disability	[ ]	[ ]

Please provide details for each item that you answered 'YES' to above:

Please list any medications (dosage & frequency) that you take on a regular basis.

PERSONAL MEDICAL HISTORY

	No	Yes
Do you currently smoke? If yes, please indicate number /day_____ OR _____ packs/day	[ ]	[ ]
Did you previously smoke? If yes, number of years quit _____ OR months quit _____	[ ]	[ ]
Are you interested in information about quitting smoking?	[ ]	[ ]
Is there any medical reason preventing you from having a driver's license? If yes, please provide details:	[ ]	[ ]
Frequent hand washing is a requirement for many positions in the hospital. Do you have any restrictions or special needs related to hand washing and the use of alcohol based hand sanitizer? If yes, please provide details:	[ ]	[ ]
Have you ever been advised to change jobs/duties because of a health problem or injury or required work restrictions related to a health problem? If yes, please provide details:	[ ]	[ ]
Do you have a disability or medical condition that may require an individual emergency plan or Emergency Response Procedures? If yes, please explain your Emergency Response needs:	[ ]	[ ]
Do you have any other health concerns you wish to discuss with the Occupational Health Nurse?	[ ]	[ ]

I am aware of the essential duties of this position and do not have any restrictions which prevent me from performing the essential duties of this position. I declare that all answers on this pre-placement health assessment are accurate and complete.

Date Year | Month | Day	**Signature of applicant**
Date Year | Month | Day	**Occupational Health Nurse**