NewYork-Presbyterian
The University Hospital of Columbia and Cornell

WH&S Annual Health Review

New York State Public Health Law requires that each Practitioner, affiliate and employee have an annual health review. This health questionnaire is for the purpose of assessing your physical and mental health status to determine your continued ability to perform your duties and responsibilities and is not a substitute for medical care

(PLEASE COMPLETE ALL QUESTIONS)

Name		Medical Record No. or SSN	Employee ID #
Home Address		Date of Birth / /	Gender: ☐ Male ☐ Female
		Home Phone No.	Work Phone/Beeper: Email Address:
Hospital/Clinical Dept.	Work Location	Job/Title	Shift: ☐NA o Day o Evening o Night

1. List all injuries, illnesses, surgeries, medical and psychological conditions you have had in the last year:

2. Are the above conditions work related? ☐ Yes ☐ No
Please explain:

3. List all medications that you take, including over the counter and alternative medicine, health food supplements and herbal remedies:

4. List all allergies and/or reactions to any medications, foods, plants, animals, chemicals or LATEX:

5. **Has your smoking status changed?** ☐ **Yes** ☐ **No** *if yes,* complete below
- Do you smoke? ☐ Yes ☐ No **how long?_____ #per day _____**
- When did you quit? _____
- Have you ever tried to quit? ☐ Yes ☐ No
- Are you ready to quit & would like information on quitting? ☐ Yes ☐ No

6. Do you drink alcohol? ? ☐ Yes ☐ No **Weekly amount?** _____
7. Check if you come into contact with any of the following (e.g., hours/day, days/week):

☐ Antineoplastics (chemotherapy)
☐ Anesthetic gases
☐ Ethylene Oxide (EtO)
☐ Formaldehyde
☐ Laser Light
☐ Blood or Body Fluids
Other _____

8. Do any of your hobbies or work-related tasks require use of the following personal protective equipment? ***Check all that apply***

☐ Respirators or Masks ☐ Safety goggles or Face Shields
☐ Latex Gloves ☐ Other equipment, specify

9. Are you employed by or affiliated with any organization other than NYPH? ☐ Yes ☐ No Where? _____

Do you have any of the following health problems/ symptoms? (please check)
If yes, are you seeing or have you seen a physician or other healthcare provider?(check below next to problem noted)

	Yes	Seeing provider?	No
Back pain/Injury	☐	☐	☐
Depression	☐	☐	☐
Memory Problems	☐	☐	☐
Seizures	☐	☐	☐
Tremor	☐	☐	☐
Unexplained Weight Loss	☐	☐	☐
Wrist /hand/arm pain	☐	☐	☐

Persistent:	Yes	Seeing provider?	No
Cough	☐	☐	☐
Diarrhea	☐	☐	☐
Fainting/dizziness	☐	☐	☐
Fever	☐	☐	☐
Night sweats (except menopausal)	☐	☐	☐
Skin rash	☐	☐	☐
Unexplained fatigue/weakness	☐	☐	☐
Unexplained weight loss	☐	☐	☐
Vision/hearing changes	☐	☐	☐

I hereby certify that I have made no misrepresentations or falsifications concerning my physical or mental health. I understand and agree that my affiliation or employment depends upon full disclosure of all my medical and mental health information and any false or misleading statements can lead to my dismissal. All answers and statements provided herein are complete and true to the best of my knowledge.

Employee Signature _____ **Date** _____

Reviewer Signature & Title _____ **Date** _____