Texas Rowning Center

EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE

This information is CONFIDENTIAL and will be used for official use only.
Please print legibly. Answer each question. Spell medical terms as close as possible.

1. _____ _____
Last Name First Name Middle Name Today's Date

2. _____
Home Address City State ZIP

3. Date of Birth _____ 4. Gender _____Male _____Female

5. Work Site _____ 6. Job Title_____
(If known)

7. State your present health status: ☐ POOR ☐ GOOD ☐ EXCELLENT

8. List medications you are currently using that may adversely affect your ability to perform Texas Rowing Center duties:

Medication	For What Condition	Since

9. List any medical conditions that you have been treated for during the past 3 years that may adversely affect your ability to perform Texas Rowing Center duties:

_____
_____
_____
_____

10. List any formal work restrictions or work limitations you are experiencing or have had in the last 3 years that may adversely affect your ability to perform Texas Rowing Center duties :

_____
_____
_____
_____

11. Year of Last Immunizations if known: Tetanus _____ Hepatitis B _____ Hepatitis A _____

12. DO YOU (Please mark your answer for each item)

Yes	No	?	
			Wear glasses or contact lenses
			Have limited vision in either eye
			Need to wear a hearing aid
			Wear a brace or support

13. **3-YEAR Health History and Self-Assessment**: The following listed medical conditions may have an impact on your ability to perform adequately as employee. As such, please mark for each category the block corresponding to your answer of **Yes, No or ? (don't know) that** you have experienced in the **past three (3) years**, Answer all categories and clarify Yes answers, by number, in the Explain Section.

Yes	No	?	PAST 3-YEARS
			1. Tested positive for Tuberculosis (TB)
			2. Known exposure to anyone with active TB
			3. Ear, nose or throat conditions
			4. Coughed up blood repetitively
			5. Chronic, on-going cough
			6. Untreatable Asthma
			7. Unusual or chronic shortness of breath
			8. Heart trouble or heart condition including chest pains or pressure
			9. Heart palpitations or unusual pounding
			10.High/Low Blood Pressure
			11. Dizziness/Fainting Spells or any seizures
			12. Rheumatic Fever
			13. Scarlet Fever
			14. Head injury
			15.Frequent or severe headaches
			16. Periods of random unconsciousness

Yes	No	?	PAST 3-YEARS
			17. Swollen or painful joints, or other joint problems
			18. Bone conditions, broken bones, brittle bones, etc.
			19. Painful or "Trick" shoulder or elbow
			20. Foot trouble
			21. Lameness
			22. Arthritis, Rheumatism or Bursitis
			23. Paralysis
			24. Recurrent back pain
			25. Any nervous disorders or anxieties
			26. Depression or excessive worry
			27. Thyroid trouble
			28. Jaundice/Hepatitis
			29. Diabetes not under control
			30. Dependency on alcohol or drugs
			31. Heat or cold related problems

Explain "Yes" answers here. Use backside of form, if needed. List dates or approximate dates of treatment received and your current status. Add any medical or mental conditions here that have not been addressed above.

14. **Addition Medical Questions**. Please check either "YES" or "NO" for each question below. Explain any Yes answers.

Yes	No	DURING THE LAST THREE (3) YEARS
-----	----	1. Have you been: (1) refused or released from employment or been (2) unable to stay in school because of:
		1a. Sensitivity to chemicals, dust, sunlight, etc…
		1b. Inability to perform certain bodily motions or repetitions in motion
		1c. Inability to assume or maintain certain positions or postures
		1d. Other medical reasons including heat or cold related problems
		2. Are you now or have you been treated for a mental health condition that you feel would affect your ability to perform adequately as a Texas Rowing Center employee?
		3. Have you had any recent surgeries that may interfere with your ability to work?
		4. Have you consulted with or been treated by health care providers, healers or other practitioners for anything other than minor illnesses and not mentioned in question number 13? If yes, explain below).
		6. Military Service: have you ever been rejected or discharged from the military because of physical, mental or other reasons? (If yes, give date and reason)
		7. Have you received, or is there pending, or have you applied for a pension, or compensation for an existing, temporary or permanent disability or impairment? If yes, specify what kind, by whom, when, and circumstances.

EXPLANATION: Please explain below any "yes" answers you made to the above questions.

_____

_____

_____

_____

15. **Physical Requirements:** Please mark which activities you can "repeatedly" perform:

	Bending		Standing for long periods of time		Operating hand-held radio's
	Reaching		Walking for long periods of time		Operating a motor vehicle
	Pushing		Run 150 feet w/out stopping		Conducting First Aid and CPR
	Pulling		Performing water based rescue		Working Overtime
	Kneeling		Swimming 150 feet w/out stopping		Working indoors or out of doors in inclement weather conditions
	Lifting		Working with general public		Working alone, when required
	Turning		Working as a team player		Working morning or evening shifts
	Crawling		Lifting and carrying rowing shells, kayaks, and canoes		

EMPLOYEE CERTIFICATION - ***I certify that I have furnished the foregoing medical information as a complete medical history for the questions asked and is true to the best of my knowledge.***

_____

Printed Employee Name Employee Signature Date Completed

EMPLOYEE'S AUTHORIZATION FOR MEDICAL RECORDS REQUEST

16. Should additional medical records or information be required to complete this medical screening, your signature below authorizes your provider to release them to TRC for this purpose. They will be held in confidence with only those who need to know having access for medical purposes only.

CONSENT & AUTHORIZATION to RELEASE MEDICAL INFORMATION - ***I hereby consent and authorize any of my doctors, health care providers, hospitals or clinics who have treated me for any of the above listed medical situations to furnish complete medical documents or transcripts of my medical records to my employer: Texas Rowing Center, ATTN: Matt Knifton + HRD, 3007 Savoy Pl, Austin, TX 78757, who will treat them with full confidentiality under the privacy rule and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.***

_____

Printed Employee Name Signature Date

MEDICAL PROVIDERS SUMMARY

Upon reviewing the employee's Medical History Questionnaire and in consultation with the employee, I find the following concerns that may or could inhibit the employee in the performance of their employee duties in a safe or effective manner.

☐ NO CONCERNS

☐ CONCERNS ARE**:** _____

_____

_____

_____

_____

_____

_____

☐ I FIND THAT ADDITIONAL MEDICAL INFORMATION WILL BE REQUIRED BEFORE THE MEDICAL SCREENING CAN BE COMPLETED. I WILL NEED THE FOLLOWING INFORMATION:

_____

Provider's Printed Name Signature Date