

Return this form to Health Services by fax.

Fax: 713-486-0983



University of Texas Employee Health Clinical Services  
Health History Questionnaire Form

TYPE OR PRINT CLEARLY

Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:	City/State/ZIP/Country:	
Your Contact Number(s):	Your email:	
Your Supervisor or Sponsoring Agency & UTH Department/School:	Job Title:	

**CONFIDENTIALITY STATEMENT:** This form requires that you provide personal health information that is protected by University policy and State and Federal law. Your rights to the confidentiality of your personal health information will be strictly maintained by Employee Health Services. Your information will be used or disclosed in accordance with those policies and laws only to the minimal extent necessary for your treatment or business operations.

If you will be participating in activities at UTHealth longer than one (1) day, please indicate your classification:

- ( ) Employee ( ) Visiting Student trainee Estimated length of stay \_\_\_ Months \_\_\_ Days  
( ) Professional trainee ( ) Visiting Scientist Estimated length of stay \_\_\_ Months \_\_\_ Days  
( ) Pre-baccalaureate trainee

Are you working in a laboratory, K-12 school, or providing Direct Patient Care?  Yes  No  Don't Know Yet  
(If "Yes", proceed to 1.TB test below. If No, go to Page 2)

**Your application will not be considered unless supporting documentation is included:**

**1. Tuberculin (TB) skin test (PPD) required within the last 6 months, even if you received BCG vaccine.**

1.1. Date of last TB skin test: \_\_\_\_\_ (ATTACH DOCUMENTATION OR LABORATORY REPORT)

1.1.1. Result (mm) \_\_\_\_\_ Negative \_\_\_\_\_ Positive (measurement \_\_\_\_\_ mm if available)

1.2. Have you ever had a positive tuberculosis (TB) skin test? \_\_\_ Yes \_\_\_ No If yes, when? \_\_\_\_\_

1.2.1. Chest x-ray findings if PPD is positive (attach x-ray report) Date of chest x-ray: \_\_\_\_\_

**2. Hepatitis B Series Three-dose series or laboratory report of positive hepatitis surface antibody titer (ATTACH DOCUMENTATION OR LABORATORY REPORT)**

2.1. #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

3. Tetanus/Diphtheria or TDAP one dose within the past 10 years. Date of last vaccination: \_\_\_\_\_

4. MMR/Measles booster Two (2) doses of measles vaccine if born after January 1, 1957, administered on or after your first birthday and at least 30 days apart. Or laboratory report of positive rubeola, mumps, and rubella titers. #1 \_\_\_\_\_ #2 \_\_\_\_\_

5. Varicella vaccine series (2 doses given at least 28 days apart) or Chicken pox disease (documented by health care provider) or positive varicella titer (attach lab report)

6. Seasonal influenza vaccination. Date \_\_\_\_\_ Attach evidence of vaccination.

**Bloodborne Pathogen Exposure Questions:**

**1.** While at The UTHealth, will you be exposed to human blood and bodily fluids?  Yes  No  Don't Know Yet

**1.1.** If you are a **visitor** and have a risk of being exposed to bloodborne pathogens while at the University; do you want UTHealth to provide the vaccine series at your expense, or perhaps refer you to another source for the vaccination series?  
 Yes  No  Don't Know Yet

If you are an **employee** and will be exposed to bloodborne pathogens here at The University of Texas, we will provide the Hepatitis B vaccine series to you at no charge.

If you are an **employee** do you want the vaccine series?  Yes  No  Don't Know Yet

**If you answered "Don't Know Yet" to either question above (1 or 1.1), you need to ask your supervisor upon arrival at your assigned location. If the answer then becomes "Yes" to either question you must inform Employee Health at 713-500-3261.**

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**If you are an EMPLOYEE and will be exposed to human blood and bodily fluid and choose NOT to accept the vaccine, please read and sign the statement below:**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B infection, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

\_\_\_\_\_  
**Employee Hepatitis B - Declination Signature**

\_\_\_\_\_  
**Date**

## Past History and Review of Systems:

**Please check if you have ever had any of the following:**

- |  |  |
|--|--|
| <input type="checkbox"/> Skin Problems.                              | <input type="checkbox"/> Diabetes/Sugar disorders                          |
| <input type="checkbox"/> Communicable Diseases.                      | <input type="checkbox"/> Neck/back/knee problems                           |
| <input type="checkbox"/> Persistent or unusual cough.                | <input type="checkbox"/> Difficulty with hearing                           |
| <input type="checkbox"/> Color blindness/vision problems             | <input type="checkbox"/> Hepatitis   |
| <input type="checkbox"/> Loss of consciousness/seizures/ convulsions | <input type="checkbox"/> Alcohol/drug abuse                                |
| <input type="checkbox"/> Unsteadiness in balance/dizzy spells        | <input type="checkbox"/> Psychiatric/emotional problems/depression/anxiety |

For any items checked above, are you or were you under the care of a physician?  Yes  No

Comments:

\_\_\_\_\_  
**Signature (Visitor and / or Employee)**

\_\_\_\_\_  
**Date**

### Office Use Only

Seasonal Influenza: \_\_\_\_\_ MMR Booster: \_\_\_\_\_ Td/TDap Booster \_\_\_\_\_

Hepatitis B Vaccine: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

TB Skin test given: Date \_\_\_\_\_ TB skin test result \_\_\_\_\_ mm Date of reading \_\_\_\_\_

Sent for CXR: Date \_\_\_\_\_ Result: \_\_\_\_\_

- Occupational Health Enrollment Form (Working with Animals)
- Respiratory Clearance form for EHS    Schedule Spirogram    Fax Respiratory Clearance form to 713.500.5841
- Not cleared