Occupational Health Services Health Assessment

Occ Health Staff Use ONLY
- ☐ Allied Health
- ☐ Resident/Fellow
- ☐ Consultant
- ☐ Research Services
- ☐ Mayo Graduate School
- ☐ Mayo School of Graduate Medical Education
- ☐ Mayo School of Health Science
- ☐ Other _____

Infectious Hazard ☐ Yes ☐ No

Start Date _____

This form is used to gather information about a Mayo Clinic employee or applicant so that Occupational Health Services may make a recommendation that relates to the employee's/applicant's job.

Name *(first name, middle name, last name)*		Mayo Clinic No. *(if known)*	Date of Birth *(dd-Mmm-yyyy)*
Social Security No.	Home Phone *(with area code)*	Home Phone *(with area code)*	

The purpose of this evaluation is to screen for communicable diseases and to determine whether you have any physical, mental, or emotional condition that could affect your ability to perform the job that you have been offered. Whenever such a condition is identified, we will attempt to specify restrictions which may allow you to perform essential functions of the job. This evaluation is not a comprehensive medical examination to diagnose or to offer medical treatment. Once you have begun your job, we encourage you to establish a relationship with a medical provider in accordance with age-appropriate guidelines and your specific needs.

I certify that the following information is true to the best of my knowledge. I understand and agree to authorize Mayo Occupational Health to review any information (including, but not limited to, information relating to psychiatric/psychological and alcohol and drug diagnosis and treatment, if any such information exists) of Mayo Clinic or other healthcare providers regarding me for purposes related to my fitness for employment. I agree to any reasonable subsequent testing or evaluation deemed necessary to determine my fitness to perform this job, and I authorize the examining provider to forward pertinent information to those who would perform such testing or evaluation. I further understand that misrepresenting facts may forfeit this employment opportunity. I understand that this record will become part of my Occupational Health file.

Signature	Date *(dd-Mmm-yyyy)*

Employment Information

Title of the Job You Have Been Offered	Department
Do you have any current disabilities requiring restricted activity? ☐ Yes ☐ No If yes, state restrictions: If yes, are these restrictions? ☐ Permanent ☐ Temporary until (date) _____	Can you perform the essential functions of this job? ☐ Yes ☐ No ☐ Uncertain Will you require an accommodation for a disability? ☐ Yes ☐ No ☐ Uncertain If you cannot perform the essential functions or require an accommodation, explain:

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MAYO CLINIC

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Functional Self-Assessment

1. Do you have any of the following *(check all that apply)*?
   - ☐ Loss of vision in either eye that cannot be corrected
   - ☐ Loss of vision requiring correction
     - select type of correction needed (if applicable):
     - ☐ Near correction ☐ Contact Lenses
     - ☐ Far correction ☐ Eyeglasses
   - ☐ Loss of hearing that requires hearing aids

2. Do you have decreased function in any of the following *(check all that apply)*?
   - ☐ Either arm/hand, including grip/reach, use of fingers
   - ☐ Neck, or lower back (such as arthritis, or pinched nerve)
   - ☐ Hips, knees, ankles or feet

3. Do you have decreased ability in any of the following *(check all that apply)*?
   - ☐ To stay awake or maintain consciousness (due to such causes as seizures, diabetes or sleep disorder)
   - ☐ To breathe or maintain endurance (due to such causes as asthma, emplysema or angina)
   - ☐ To fight off infection (due to such causes as immune deficiency or diabetes)

If you selected any of the above, provide comments below:

4. Do you have physicial problems (such as ☐ seizure disorder, or ☐ diabetes) or ☐ mental/emotional problems (such as ☐ anxiety, ☐ attention deficit disorder, or ☐ claustrophobia) that could interfere with any of the following *(check all that apply)*?
   - ☐ Working in confined spaces
   - ☐ Working at heights
   - ☐ Working in extreme cold or heat
   - ☐ Working with moving machinery
   - ☐ Driving company vehicles (car, truck, forklift)
   - ☐ Working with soaps, detergents or solvents
   - ☐ Using a respirator
   - ☐ Using latex products
   - ☐ Working rotating shifts (nights, evenings)
   - ☐ Working with animals
   - ☐ Working with radiation or chemotherapy agents (due to a condition such as pregnancy)
   - ☐ Managing multiple tasks at one time

If you selected any of the above, provide comments below:

Personal History

1. Are you taking any medications? ☐ Yes ☐ No
   If yes, list all prescription and non-prescrition medications you currently take including dosage, frequency, indication:

Medication	Dosage	Freqency	Indication

2. Do you have any allergies (such as bee stings, medications, latex, metals)? ☐ Yes ☐ No
   If yes, provide list:

3. In the past 6 months, have you been referred to, admitted to or discharged from a drug/alcohol rehabilitation program? ☐ Yes ☐ No
   If yes, please provide details:

4. Are you currently in any mandated program by your licensing agency regarding substance abuse? ☐ Yes ☐ No
   If yes, please provide details:

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