



## NEW RESIDENT INFORMATION SHEET

Please complete the following as accurately as possible.

**(All requested information is required to establish your record with Employee Health & Wellness)**

**(PLEASE PRINT)**

|                            |                    |
|----------------------------|--------------------|
| Name (Complete Legal Name) |                    |
| Date of Birth              |                    |
| Social Security Number     |                    |
| Gender                     |                    |
| Mother's Maiden Name       |                    |
| Local Address              |                    |
| Local City, State, Zip     |                    |
| Local County of Residence  |                    |
| Home Telephone             |                    |
| Cell Telephone             |                    |
| E-Mail Address             |                    |
| Employer                   | Augusta University |
| <b>DEPARTMENT NAME</b>     |                    |
| Program Year               |                    |
| Start Date                 | 07/01/2018         |
|                            |                    |

If you have any questions or need assistance please contact:

Employee Health & Wellness  
706/721-3418 Office  
706/721-0882 Fax



**EMPLOYEE HEALTH & WELLNESS  
NEW EMPLOYEE HEALTH HISTORY (Please Print)**

(Label)

**Personal Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security#: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Daytime Telephone: \_\_\_\_\_ Department Name & Extension: \_\_\_\_\_ E-mail address: \_\_\_\_\_

**Please check all that apply:**

|                                  |   |                                       |
|----------------------------------|---|---------------------------------------|
| Skin rashes or skin irritation   | Back or neck pain or injury             | Cirrhosis, Jaundice, Hepatitis        |
| Hives                            | Vertebral disc problems                 | Gastritis or GERD                     |
| Reaction to soap/detergents      | History of falling                      | Hernia repair                         |
| Glasses for reading              | Sacroiliac pain                         | Abdominal surgery                     |
| Glasses for distance vision      | Missed work due to back pain            | Excessive weight loss/gain            |
| Wear contact lenses              | Shoulder or arm pain or injury          | Anemia or polycythemia                |
| Color blind                      | Leg or knee pain or injury              | Night sweats                          |
| Other visual problems            | Swollen joints                          | Diabetes                              |
| Difficulty hearing               | Arthritis or gout                       | Hypo or Hyper thyroid or goiter       |
| Use hearing aide(s)              | Bursitis or tendonitis                  | Kidney problems                       |
| Chest pain                       | Trouble walking / standing for > 1 hour | Chicken Pox                           |
| High blood pressure              | Trouble sitting for long periods        | Shingles                              |
| High cholesterol                 | Back or neck surgery                    | Red Measles (Rubeola)                 |
| Shortness of breath              | Shoulder, elbow, wrist, hand surgery    | Mumps                                 |
| Swelling of the ankles           | Knee, ankle or foot surgery             | <b>Previous Jobs Involving:</b>       |
| Heart murmur                     | Facial or dental surgery                | Highly repetitive motions             |
| Heart palpitations               | Arm, wrist or hand weakness             | Power / vibration tools               |
| Heart surgeries                  | Leg, knee, ankle or foot weakness       | Laser                                 |
| Seasonal allergies               | Arm or leg numbness                     | Exposure to dust / fumes / chemicals  |
| Chronic cough                    | Dizziness, fainting spells              | <b>Any difficulty working due to:</b> |
| Asthma, bronchitis or COPD       | Frequent / severe headaches             | Stress, anxiety, or depression        |
| Cough with blood                 | Seizures or convulsions                 |                                       |
| History of positive TB Skin Test | Multiple sclerosis                      | Smoke cigarettes                      |
| History of receiving BCG Vaccine | Neuromuscular disorder                  | Use other tobacco products            |

List allergies to medications:

Are you allergic to rubber, latex or powder in gloves? Yes No  
 Do your lips swell or itch after you blow up a balloon? Yes No  
 Have you had swelling, itching or trouble breathing swallowing during dental procedures? Yes No  
 Have you had eczema or rashes on your hands? Yes No  
 Have you had rashes, hives or other reactions to wearing gloves or to powder in gloves? Yes No  
 Are you allergic to fruits, vegetables, seafood, peanuts, iodine, etc? (Please explain) Yes No

**SEASONAL INFLUENZA VACCINATION POLICY FOR ALL AUGUSTA UNIVERSITY HEALTH SYSTEM, AUGUSTA UNIVERSITY, IF ASED VOLUNTEERS, CONTRACTORS, CREDENTIALLED PROVIDERS: I have been informed and understand that the vaccination is a condition of my employment and refusing to comply with the policy will result in termination of employment:**

(Signature)

What medications do you currently take? \_\_\_\_\_  
 List surgical procedures (date): \_\_\_\_\_

Have you had any accident, injuries or medical conditions that have prevented you from doing your work related duties in the past? YES NO  
 (if yes, please explain) \_\_\_\_\_  
 Are you medically capable of performing all critical functions of your job descriptions as detailed by Human Resources? YES NO  
 (if no, please explain) \_\_\_\_\_  
 Do you anticipate the need for any accommodations to perform the duties of your job description? YES NO  
 (if yes, please explain) \_\_\_\_\_



**Employee Health & Wellness  
OSHA RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE**

Employer: Health System  University  Medical Associates  Contractors

**Part A. Section 1(Mandatory)**

Today's Date: \_\_\_\_\_ Your Name: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Department: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Last 5 numbers of your SSN: XXX-X\_\_-\_\_\_\_\_  
 Have you worn a respirator:  Yes  No  
 If "yes," what type(s): \_\_\_\_\_

**Note: If you will wear half or full mask facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus please complete supplemental questionnaire.**

**Part A. Section 2 (Mandatory)**

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month:  Yes  No
2. Have you ever had any of the following conditions? (Mark all that apply)

**Lung Problems:**

|                           |                      |                        |              |                     |
|---------------------------|----------------------|------------------------|--------------|---------------------|
| Allergic reactions        | Anaphylaxis          | Trouble smelling odors |              |                     |
| Asthma                    | Chronic bronchitis   | COPD/Emphysema         | Wheezing     | Shortness of breath |
| Tuberculosis              | Pneumonia            | Lung cancer            | Pneumothorax | Chronic cough       |
| Chest pain with breathing | Chest injury/surgery | Broken ribs            | Asbestosis   | Silicosis           |

**Heart Problems:**

|               |                       |                          |            |                |
|---------------|-----------------------|--------------------------|------------|----------------|
| Angina        | Chest pain            | Heart attack or MI       | Arrhythmia | Heart skipping |
| Heart failure | Swelling in legs/feet | Heartburn or indigestion |            |                |

**Miscellaneous:**

|              |                   |        |          |                |
|--------------|-------------------|--------|----------|----------------|
| Hypertension | Diabetes mellitus | Stroke | Seizures | Claustrophobia |
|--------------|-------------------|--------|----------|----------------|

3. Please list your prescribed medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Do you have any other symptoms which concern you or may affect respirator use? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Have you ever had any of these symptoms while wearing a respirator?

Eye irritation Yes  No  Skin allergies or rashes Yes  No   
General Weakness or fatigue Yes  No  Anxiety Yes  No

6. Have you ever had any other problems wearing a respirator before? Yes  No

7. Would you like to speak with a health care professional who will review this questionnaire about your answers to this questionnaire?  Yes  No

8. Do you have any other medical questions about this questionnaire? Yes  No

**TO BE COMPLETED BY EMPLOYEE HEALTH STAFF**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Type Respirator Fit Tested: \_\_\_\_\_  Small  Medium  Large

Passed  Failed

If failed; was employee provided with information, demonstration, and education for PAPR?

Yes  No (If no, why not?) \_\_\_\_\_

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reviewed by: \_\_\_\_\_  
James A. Foster, MD, Medical Director, Employee Health & Wellness



Employee Health & Wellness
Authorization to Obtain or Disclose
Employee Health Information

STAFF USE ONLY:
(Employee Health & Wellness MRN)

Employee Name:
Employer:
Augusta University Health System
XX Augusta University
Medical Office Associates, fka PPG
Leased Contract Volunteer

Date:
Social Security Number:
Date of Birth:

\*Please list any former name / maiden name:

I request to obtain a copy of the records of the above named employee's health information as described below, concerning the period from to
My signature below gives Employee Health & Wellness authorization to disclose the above named employee's health information as described below, concerning the period from to. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: . If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

Medical records requested:
XX Tuberculin Skin Test results
XX Vaccinations and titers
XX Drug Screen Results
Cotinine Testing Results
Other (please specify):

This information may be disclosed to and used by the following individual or organization:
Name/Address: RESIDENCY COORDINATOR FOR MY SPECIFIC AREA (Initial Here)
Fax Number:
Purpose:
Special instructions:

XX By signing below, I authorize Employee Health & Wellness to release any and all records related to my post hire employment visit and annual health visit (including, but not limited to, drug screening status and results, tuberculosis screening, immunization titers, vaccinations, respiratory fit testing, and physician examination). These records may be released to the Human Resources department of Augusta University and/or Augusta University Health System. If I am a temporary, agency, or contracted employee, the above mentioned records may also be released to the company I am directly employed by. This authorization is valid for ONE YEAR.

I understand that I have a right to revoke authorization for release of my employee health information at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Employee Health & Wellness. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Employee Health & Wellness at (706) 721-3418: (Fax #706-721-0882)

Signature of Employee or Legal Representative Date

If Signed by Legal Rep, Relationship to Employee & Signature of Witness Required Date