

# Tufts Medical Center

Employee Health Services  
800 Washington Street, Box # 801  
Boston, MA 02111  
Ph: 617-636-5480  
Fax: 617-636-6211

**The following infection control Immunization requirements will need to be satisfied before you start work:**

1. **TB SCREENING** You will need proof of a TB skin test within the past six months. If you have not had this screening, it will be offered here in Employee Health. Individuals with a previous, positive PPD test will need to complete a symptom questionnaire, provide documentation of their evaluation and/or treatment, including a chest x-ray report. If no CXR report is available, we will arrange to have a CXR taken here.
2. **TETANUS AND DIPHTHERIA (Td) BOOSTER** You will need proof of a Td booster within the past 10 years. If you are unsure of your status, or cannot provide documentation, we will provide you with an updated Td or Tdap booster.
3. **MEASLES, MUMPS AND RUBELLA (MMR)** vaccine(s) documentation. If you were born after 1957, you need documentation of two MMR vaccinations, or positive serologies, showing that you have immunity against these viruses. If you were born before 1957, only one vaccination is required.
4. **HEPATITIS B IMMUNIZATION AND EVIDENCE OF HBV ANTIBODY** If you have had the 3 vaccines series and/or have had an HBV antibody response, please send the documentation, including the dates. If you have not received the vaccine, you will need to obtain it, or sign a waiver that you decline vaccination. We offer the Hepatitis B Vaccination to all new physicians if needed.
5. **CHICKENPOX (VARICELLA)** If you know that you have had chickenpox, verbal acknowledgement will be sufficient. If you are not sure, then serology testing can determine whether you have had this infection in the past.
6. **RESPIRATORY QUESTIONNAIRE** You will be required to have a respirator fit test on record here at the Hospital. Prior to fit testing, you must complete the enclosed questionnaire. Please send this completed form to us with the above documentation. When you start here at Tufts MC, you will need to schedule an appointment for respirator fit testing with Environmental Health Services 617-636-5024.

After these infection control requirements are completed, you will be cleared to start work. We look forward to meeting you.

<b>MEDICAL RECORD CARD INFORMATION</b>		<b>For New Employees Only: Department you will work for</b>	
Name		Last	First
		Middle	Sex
Street		Telephone	
City, State		Zip	
Birthdate	Place of Birth		
Maiden Name	Father's First Name	Mother's First Name	Spouse's First Name
Have you ever worked or been treated anywhere at Tufts Medical Center?		Marital Status (check one)	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
<b>FOR HOSPITAL USE ONLY</b>			
Appointment Date		Medical Record Number	

Revised 2/2010

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## Employee Health Services Confidential Health History

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

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Work Start Date: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

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Primary Care Physician: \_\_\_\_\_

Office Location: \_\_\_\_\_

Date Last Visited: \_\_\_\_\_

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Allergies to food or medicine: \_\_\_\_\_

List all medications you take at least once per month: \_\_\_\_\_

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Past Medical History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Hospitalizations/Surgeries:**

How many cigarettes do you smoke per day? \_\_\_\_\_

How much alcohol do you consume per week: \_\_\_\_\_

Have you ever had Chickenpox? \_\_\_\_\_

**Tuberculosis Screening**

When was your last tuberculosis skin test? \_\_\_\_\_

What was the results? \_\_\_\_\_

If you have had a positive TB test, have you taken INH? (Indicate Dates) \_\_\_\_\_

\_\_\_\_\_

**Occupational Health History**

A "yes" response to any of the following questions will not affect your employment, rather it will help us determine if you require any special accommodations in order to perform your job at Tufts Medical Center.

Are you known to be allergic to natural rubber (latex)? \_\_\_\_\_

Do you sometime get red irritated hands from wearing rubber gloves? \_\_\_\_\_

Have you ever experienced water eyes, sneezing, asthma or other allergic symptoms when in area where latex gloves are worn? \_\_\_\_\_

Have you ever had a health problem caused by exposure to chemicals or radiation at work? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been accidentally struck by a needle or otherwise exposed to blood during the course of your job? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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MEDICAL HISTORY	Do you have or have you ever had any of the following? (Please check)	Yes	No
	1. Has your blood pressure been checked in the last 2 years? If yes, were you told that your blood pressure was normal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	2. Stroke		
	3. Heart attack		
	4. Abnormal EKG		
	5. Abnormal stress test		
	6. Other heart trouble		
	7. Chronic bronchitis		
	8. Emphysema		
	9. Pneumothorax (collapsed lung)		
	10. Injury or surgery affecting the shape of your jaws or cheeks?		
	11. Asthma	Yes	No
a. Have you been hospitalized, had an Emergency Room visit for treatment or missed work due to asthma in the last year? Date last treated _____			
b. Do you use a short-acting medicine for asthma (albuterol, ventolin, proventil) more than twice a week?			
c. Are you currently having symptoms of cough, wheeze or shortness of breath more than once a week in the daytime or once a month at night?			
12. Do you take any medicines for heart, lung or seizure problems?			
REVIEW OF SYMPTOMS	Have you experienced any of the following symptoms in the past year?	Yes	No
1. Shortness of breath			
2. A cough lasting more than 1 month			
3. Wheezing			
4. Chest pain and tightness			
5. Palpitations or racing heart beat			
6. Swelling of the ankles and/or feet			
7. Facial rash			
8. Do you have any other medical conditions that might affect your ability to use a respirator?			

If yes to any of the above, please list: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>OHS USE ONLY</b>	<b>Determination:</b> If smoker, _____ pack/per day x _____ # of years = _____ pack-year history <input type="checkbox"/> Medically cleared for respirator fit testing. <i>Date due for re-screen:</i> _____ <input type="checkbox"/> Cleared to use a respirator with restrictions <i>Specify:</i> _____ <i>Initials</i> _____ <input type="checkbox"/> Requires additional screening <i>Specify:</i> _____ <i>Initials</i> _____ <i>Follow-up (if any):</i> _____ <i>Initials</i> _____
	<b>Date:</b> _____ <b>Reviewer Signature:</b> _____