EVMS
Eastern Virginia Medical School

Occupational Health

Phone: 757-446-5870 FAX: 757-446-7188

To: Incoming Residents and Fellows

Re: Health Requirements for Residents and Fellows at EVMS

Welcome to Eastern Virginia Medical School (EVMS). Incoming residents and fellows must have a physical exam performed by a physician, nurse practitioner, or physician's assistant who is not in your residency or fellowship program and who is not related to you within four months prior to your residency start date. You are responsible for the costs of all health requirements including the physical exam, immunizations, antibody titers, tuberculosis testing, and chest x-ray if indicated. Occupational Health cannot perform your physical examination.

EVMS adheres to the Centers for Disease Control (CDC) guidelines regarding immunization of health-care workers. You must provide copies of immunization documentation (i.e. shot records), laboratory reports indicating immunity, and documentation of tuberculosis tests if applicable. If you have previously had a positive tuberculosis test, you will be required to complete the enclosed TB Symptom Surveillance Questionnaire, as well as provide documentation of evaluation for treatment, and chest x-ray report from the past twelve months prior to program start date. You must submit all health requirement documentation to Occupational Health by May 11th. Failure to comply with the School's health requirements may delay the beginning of your residency or fellowship program.

Do not return medical forms to the program you are entering. Please keep a copy of original documents for your personal records. All documents should be mailed to Occupational Health at the following address:

Eastern Virginia Medical School
735 Fairfax Avenue
Norfolk, VA 23507
Attn: Occupational Health (Suite 926)

In addition, employment is contingent upon the successful completion of a drug screen.
Drug screens can be scheduled in Occupational Health by calling (757) 446-5870.

Eastern Virginia Medical School
Pre-Placement Medical Questionnaire/Physical Exam

ARE YOU A CURRENT OR FORMER EVMS STUDENT? ☐ YES or ☐ NO

Section 1: Identification

Applicant Name: ____

Sex: Female Male

Social Security Number: _xxx____/___xx___/____________

Date of Birth:________/________/________

Height:______Ft.______In.

Weight:

Department: ______________________________________

Job Title: ______________________________________

This form is to help the medical provider assess your ability to perform the essential functions of the job for which you have applied, whether accommodations are appropriate or required, and/or your need for special or emergency procedures. Some job classifications may require additional information and examination. This information is confidential. It will be part of your medical record.

Relative to this job, is there any health-related condition for which you require accommodation, i.e. job modification, structural changes to the work area? If so, please list:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Section 2: Personal Medical History

Have you ever had any of the following? (Please Circle)

Allergies/allergic reaction	YES	NO	Heart attack	YES	NO
Angina	YES	NO	Irregular heart beat	YES	NO
Asthma	YES	NO	Pain or tightness in your chest	YES	NO
Back problems	YES	NO	High blood pressure	YES	NO
Chest injury	YES	NO	Hearing/ear problems	YES	NO
Chronic bronchitis	YES	NO	Hepatitis	YES	NO
Claustrophobia	YES	NO	Kidney disease	YES	NO
Diabetes	YES	NO	Lung disease	YES	NO
Ear injury	YES	NO	Pneumothorax	YES	NO
Emphysema	YES	NO	Seizures	YES	NO
Epilepsy	YES	NO	Stroke	YES	NO

If yes to any, please explain: ____

____

Do you currently have any of the following symptoms of pulmonary or lung illness? (Please Circle)

Shortness of breath	YES	NO
Shortness of breath when walking on level ground or up a slight incline	YES	NO
Shortness of breath when walking with others at an ordinary pace on level ground	YES	NO

Have to stop for breath when washing or dressing yourself	YES	NO
Coughing that produces phlegm (thick sputum)	YES	NO
Coughing that wakes you up early in the morning	YES	NO
Coughing that occurs mostly when you are lying down	YES	NO
Coughing up blood in the last month	YES	NO
Wheezing	YES	NO
Chest pain when you breathe deeply	YES	NO
Any other symptoms that you think may be related to breathing problems	YES	NO

If yes to any, please explain: ____

____

Do you currently have any of the following musculoskeletal problems? (Please Circle)

Weakness in any of your arms, legs, or feet	YES	NO
Back pain	YES	NO
Difficulty fully moving your arms or legs	YES	NO
Pain or stiffness when you lean forward or backward at the waist	YES	NO
Difficulty moving your head up and down or side to side	YES	NO
Difficulty bending at the knees	YES	NO
Difficulty squatting to the ground	YES	NO
Difficulty climbing a ladder or stairs carrying more than 25 pounds	YES	NO
Any other muscle or skeletal problem	YES	NO

If yes to any, please explain: ____

List any hospitalizations you have had, reason, and date: ____

____

Have you ever been injured or exposed at a previous job? (Exposure includes, but is not limited to, blood/body fluid exposures, hazardous material/chemical spills, infectious disease exposures, etc.) If so, please list:

____

Has your physical activity been restricted or have you lost time from work during the past five years? If so, please explain:

____

Section 3: Allergies and Exposures

Have you ever had a reaction, allergy, or sensitivity to any drugs (such as codeine or penicillin), food, plants, chemicals, or latex?

____

____

Have you ever worked with any of the following? (Please Circle)

Anesthetic gases	YES	NO	Lasers	YES	NO
Antineoplastic/cytotoxic drugs	YES	NO	Lead	YES	NO
Asbestos	YES	NO	Pesticides	YES	NO
Ethylene oxide	YES	NO	Radiation/radioactive material	YES	NO
Formaldehyde	YES	NO	Animal dander	YES	NO
Glutaraldehyde (Cidex)	YES	NO	Any other substances	YES	NO

If yes to any, please explain: ____

____

Section 4: Hearing and Vision

Do you currently have any of the following hearing or vision problems? (Please Circle)

Difficulty hearing	YES	NO	Near Sighted	YES	NO
Wearing a hearing aid	YES	NO	Far Sighted	YES	NO
Have you ever had injury to your ears, including a broken eardrum?	YES	NO	Have you ever lost vision in either eye (temporarily or permanently)?	YES	NO
Any other hearing or ear problems?	YES	NO	Any other vision or eye problems?	YES	NO
Color blind	YES	NO	Do you wear contact lenses or glasses?	YES	NO

If yes to any, please explain:____

____

When was your last eye exam?_________________________

Section 5: Respirators Applies to anyone that may have to wear a respirator to perform certain tasks, i.e., TB protection, organic vapor protection, etc.

Have you used a respirator? Yes _____ No _____

If you have used a respirator, have you ever had any of the following problems? (Please Circle)

Eye irritation	YES	NO
Skin allergies or rash	YES	NO
Anxiety	YES	NO
General weakness or fatigue	YES	NO
Any other problem that interferes with your use of a respirator	YES	NO
Any other muscle or skeletal problem	YES	NO

If yes to any, please explain: ____

Section 6: TB Risk Assessment

The CDC recommends that a TB risk assessment be a part of baseline TB screening for Health Care Workers. This helps in interpreting results.

1. Temporary or permanent residence (for ≥1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)

Or

2. Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication (Abbreviation: TNF = tumor necrosis factor).

Or

3. Close contact with someone who has had infectious TB disease since the last TB test

Do you have any of the above risks?	YES	NO	If yes, which risk factor?	1.	2.	3.

Section 7: Medications

Are you are currently taking medications for any of the following conditions? (Please Circle)

Breathing or lung problems	YES	NO	Heart trouble	YES	NO
Blood pressure	YES	NO	Seizures	YES	NO

If yes to any, please explain: ____

____

List other medications that you currently taking: ____

____

Do you take any medications or have any medical conditions to disclose in case of a medical emergency? __________________

____

Do you take medications before or during work, which you believe could affect your physical or mental function or performance? (If yes, please list: ____

Do you have any other health problems, concerns, or limitations? ____

____

Privacy Statement: The information contained in this form is strictly confidential and is kept only in Eastern Virginia Medical School Occupational Health. The Medical Director, the Occupational Health staff, or the treating Physician without your express consent may only view the contents of this file. Your records will not be released without your consent unless mandated by regulatory or legal request.

I the undersigned, certify the above information to be true. I understand that my employment is contingent on a recommendation of Occupational Health regarding fitness for duty. Falsification of any information in this questionnaire may result in disciplinary action including termination of employment.

____

Applicant's Signature Date

Section 8: Complete EVMS Immunization form and TB status. **IGRA REQUIRED unless not available.**

Section 9: Physical Examination by a physician, nurse practitioner or physician assistant within four (4) months prior to the program start date. Examinations performed by a first-degree relative or in-law will not be accepted.

Applicant/Patient Name: ____

Date of Birth: __________ Weight: __________ lb. Height __________ ft. __________ in.

B/P: _______________ Pulse: ______________

Far Vision: __________ Corrected | Near Vision: __________ Corrected

Far Vision: __________ Uncorrected | Near Vision: __________ Uncorrected

Exam: Comment:

________ Skin ____
________ Head ____
________ Neck ____
________ Ears ____
________ Eyes ____
________ Nose ____
________ Mouth ____
________ Heart ____
________ Lung ____
________ Chest ____
________ Abdomen ____
________ Derm ____
________ Extremities ____
________ Neurological ____
________ Orthopedic ____
________ Other ____

Physician/Provider's Name: ___________________________________

Address: ____

City: ___________________________ State: ___________ Zip Code:______________

Phone: (___)_____-__________ Fax: (____)_____-_________

___________________________________ ____________________

Signature Date

Tuberculosis Symptom Surveillance Questionnaire

(Please complete this form ONLY if you have had a PREVIOUS POSITIVE Tuberculosis Test or Diagnosis of active Tuberculosis.)

Name:____ DOB:_______/_____/_____

Program: ______________________________________ Year: ___________________

Do you have a chronic cough? YES NO
If yes, for how long? ____

Have you had unexplained weight loss? YES NO
If yes, please explain. ____

Do you suffer from malaise? YES NO
If yes, please explain.____

Do you suffer from night sweats? YES NO
If yes, please explain. ____

Do you have an unexplained fever? YES NO
If yes, for how long? ____

Do you have chest pain? YES NO
If yes, please explain. ____

Are you coughing up blood? YES NO
If yes, please explain. ____

_______________________________________ _____________________________________
Signature Date

_______________________________________ _____________________________________
Reviewed by (Occupational Health) Date