EMPLOYEE HEALTH SERVICES

Confidential New-Employee Health Questionnaire

*Please complete after acceptance of your Swedish job offer and prior to your first day of work.*

Swedish Medical Center wants to assure that you are physically prepared for your new job. We also want to determine if you have immunity to certain communicable diseases in order to protect you and our patients. Normally, Employee Health Services interviews all new hires during the first day of orientation. Please bring your completed questionnaire and documentation of your immunizations with you to orientation. If you are not scheduled for orientation, call Employee Health Services for an appointment (see below for phone numbers for each campus).

- **Tuberculosis Skin Test (TST)**
  Washington state requires two TSTs upon hire for all new health-care staff who have had a negative TST or who have never had a TST. If you do not have documentation of receiving a TST within the last 12 months, you will need to have two TSTs done one week apart. With documentation of one TST within the last 12 months, you will only need to receive one TST.

  TST-positive individuals do not need to have a TST, but must provide documentation of their previously positive TST and a chest X-ray report. If no chest X-ray report is available, you will be referred for a chest X-ray at no cost to you.

- **Hepatitis B**
  Documentation of initial series of three vaccines with dates, any boosters with dates, and any post vaccination lab results with dates.

- **MMR (Measles, Mumps and Rubella) Vaccine**
  One of the following:
  - Documentation of all vaccines related to MMR with dates, or
  - Evidence of immunity by lab test with dates, or
  - Documentation from a physician indicating previous illness with measles, mumps or rubella

- **Chicken Pox (Varicella Zoster or shingles)**
  One of the following:
  - Documentation from a physician or statement of previous history of disease
  - Evidence of immunity by lab test with dates, or
  - Documentation of vaccine with dates

- **Annual Flu Vaccine**

- **Tdap Booster**
  One-time Tdap booster is the Centers for Disease Control (CDC) recommendation for all adults and all health-care personnel.

Individuals without prior immunity may be offered free vaccine by Swedish Medical Center if warranted by their job description and the potential for on-the-job exposure.

*If you have any questions about documentation or immunity, please call Employee Health Services:*

- Ballard campus: 206-781-6140
- Cherry Hill campus: 206-320-2845
- Edmonds campus: 425-640-4133
- First Hill campus: 206-386-6048
- Issaquah campus: 425-313-7024
Please complete all sections. Print clearly.

Date of Orientation: ______/_____/______

Name _______________________________ LAST FIRST MIDDLE

Social Security Number ____________________________ Sex: MALE ☐ FEMALE ☐

Address (INCLUDING APARTMENT NUMBER, P.O. BOX, ETC.) _________________________________

CITY __________________ STATE ______ ZIP ______

Phone (INCLUDING AREA CODE) _______ _______________________________ Date of Birth ______________

Department ______________________ Title ______________________

Shift: DAY ☐ EVENING ☐ NIGHT ☐ PER DIEM ☐

Campus: BALLARD ☐ CHERRY HILL ☐ EDMONDS ☐ FIRST HILL ☐ ISSAQUAH ☐ SWEDISH MEDICAL GROUP ☐

Primary-Care Physician _________________________________

Physician’s Phone Number (INCLUDING AREA CODE) _______ ________________________________

1. Have you ever worked for Swedish Medical Center (or Swedish Medical Group) before?
   Yes ☐ From_______YEAR To_______YEAR Campus: ________________________________
   No ☐

2. Have you ever volunteered at Swedish Medical Center?
   Yes ☐ From_______YEAR To_______YEAR Campus: ________________________________
   No ☐

3. Are you allergic to any medications? Yes ☐ No ☐
   If yes, please list them. __________________________________________________________
   Do you have any severe allergic reactions? Yes ☐ No ☐
   If yes, please list the allergy and type of reaction. ______________________________________

4. Have you received the Hepatitis A Vaccine?
   Yes ☐ Date 1st: __________________________
   No ☐ 2nd: __________________________
   Unknown ☐

5. Have you received the Hepatitis B Vaccine? Please provide documentation.
   Yes ☐ Date 1st: __________________________ 4th: __________________________
   No ☐ 2nd: __________________________ 5th: __________________________
   Unknown ☐ 3rd: __________________________ 6th: __________________________

6. Have you been tested for immunity to Hepatitis B?
   Yes ☐ Results: ☐ Positive (have immunity) Date: __________________________
   No ☐ ☐ Negative (no immunity)
   Unknown ☐
7. Have you ever had the Chicken Pox? Yes □ No □
   Have you been tested for immunity? Yes □ No □ Results: __________________________
   Have you had the Varivax (Chicken Pox) Vaccine?
   Yes □ → Date 1st: __________________________
   No □ 2nd: __________________________
   Unknown □

8. Have you ever received the MMR (Measles, Mumps and Rubella) Vaccine?
   Yes □ → Date: 1st: __________________________ Please provide documentation.
   No □ 2nd: __________________________
   Unknown □

9. Have you been lab tested for immunity to:
   A. Rubella (German Measles)?
      Yes □ → Date: __________________________ Results: __________________________
      No □
      Unknown □
   B. Rubeola (Hard Measles, Red Measles)?
      Yes □ → Date: __________________________ Results: __________________________
      No □
      Unknown □
   C. Mumps?
      Yes □ → Date: __________________________ Results: __________________________
      No □
      Unknown □

10. Date of last Tetanus-diphtheria-pertussis (TDAP)? __________
     or Tetanus-diphtheria Booster (TD)? __________
     Unknown □

11. Date of last seasonal flu vaccine? __________

12. As a new employee, you are required to have two Tuberculin skin tests (TSTs) upon hire.
    Have you had a TST within the past year?
    Yes □ → Date: __________________________ Please provide documentation.
    No □
    Unknown □
    Have you ever had a positive TST?
    Yes □ → Date: __________________________ Please provide documentation.
    No □
    Unknown □
    Date of last Chest X-ray (if applicable): __________ Results: __________________________

    Have you ever received the BCG vaccine (if applicable)?
    Yes □ → Date: __________________________
    No □

I, the undersigned, certify the above answers are true, and I realize willful misrepresentation may lead to termination.
Signature: __________________________ Date: __________
Unknown