Clinical services provided and/or recorded by Marshfield Clinic Employee Health Services, Marshfield, WI.
Record/Results Printed: 11/16/2017 11:57 am

Employee: **Guo, Shicheng**

Medical History Survey

Part 1 - Medical History

This survey requests information about your current health and information that will help the Employee Health Services provide care for you and promote wellness.

Only those questions marked with a red asterisk must be answered in order to submit the survey. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1) Are you currently under the care of a health care provider (doctor, chiropractor, pain management, etc.)?

- ○ Yes
- ◉ No

2) Primary care physician's name:

3) Primary care physician's phone:

4) When was the last time you had a complete physical with a doctor? (year)

Prescriptions

5) Are you currently on any prescription medications?

- ○ Yes
- ◉ No

6) If yes, please list prescription medications:

Allergies

7) Do you have any allergies to medications or chemicals (including latex)?

- ○ Yes
- ◉ No Known Allergies

8) If yes, please list allergies:

Surgeries, Serious Illnesses, Injuries, or Hospitalizations

9) Have you had any surgeries, serious illnesses, injuries, or hospitalizations?

- ○ Yes
- ○ No
- ◉ Not applicable

10) If yes, please list any surgeries, serious illnesses, injuries, or hospitalizations, including the diagnosis and year:

Health History

Have you ever had any of the following conditions? (Select all that apply)

11) Ear infections

- ☑ Ear infections

12) Hearing loss

- ☐ Hearing loss

13) Eye infections

- ☐ Eye infections

14) Failing vision

- ☐ Failing vision

15) Glaucoma/cataracts

- ☐ Glaucoma/cataracts

16) Color blindness

- [ ] Color blindness

17) Hay fever/allergies

- [ ] Hay fever/allergies

18) Nose bleeds

- [ ] Nose bleeds

19) Sinus trouble

- [ ] Sinus trouble

20) Sleep apnea

- [ ] Sleep apnea

21) Cold sores

- [ ] Cold sores

22) Asthma

- [ ] Asthma

23) Bronchitis/chronic cough

- [ ] Bronchitis/chronic cough

24) Pneumonia

- [ ] Pneumonia

25) Tuberculosis

- [ ] Tuberculosis

26) Coronary artery disease

- [ ] Coronary artery disease

27) Heart murmur

- [ ] Heart murmur

28) High blood pressure

- [ ] High blood pressure

29) High cholesterol or other lipids

- [ ] High cholesterol or other lipids

30) Irregular heart beat

- [ ] Irregular heart beat

31) Stroke

- [ ] Stroke

32) Thyroid disease

- [ ] Thyroid disease

33) Diabetes

- [ ] Diabetes

34) Complications with pregnancy

- [ ] Complications with pregnancy

35) Gallbladder trouble

- [ ] Gallbladder trouble

36) Hepatitis A

- [ ] Hepatitis A

37) Hepatitis B

- [ ] Hepatitis B

38) Hepatitis C

- [ ] Hepatitis C

39) Other liver disease

- [ ] Other liver disease

40) Gastroesophageal Reflux Disease (GERD)

- [ ] Gastroesophageal Reflux Disease (GERD)

41) Peptic ulcers

- [ ] Peptic ulcers

42) Diverticulitis

- [ ] Diverticulitis

43) Crohn's Disease/Colitis

- [ ] Crohn's Disease/Colitis

44) Irritable bowel syndrome

- [ ] Irritable bowel syndrome

45) Hernia

- [ ] Hernia

46) Anemia

- [ ] Anemia

47) Bleeding disorder

- [ ] Bleeding disorder

48) Arthritis

- [ ] Arthritis

49) Auto immune disease

- [ ] Auto immune disease

50) Gout

- [ ] Gout

51) Fibromyalgia

- [ ] Fibromyalgia

52) Osteoporosis

- [ ] Osteoporosis

53) Back pain/chronic recurrent

- [ ] Back pain/chronic recurrent

54) Neck pain

- [x] Neck pain

55) Carpal tunnel syndrome

- [ ] Carpal tunnel syndrome

56) Wrist problems

- [ ] Wrist problems

57) Elbow problems

- [ ] Elbow problems

58) Shoulder problems

☐ Shoulder problems

59) Foot/ankle problems

☐ Foot/ankle problems

60) Knee problems

☐ Knee problems

61) Muscle disease

☐ Muscle disease

62) Headaches - frequent

☐ Headaches - frequent

63) Migraines

☐ Migraines

64) Parkinson's Disease

☐ Parkinson's Disease

65) Epilepsy or seizure disorder

☐ Epilepsy or seizure disorder

66) Psychiatric/psychological condition

☐ Psychiatric/psychological condition

67) Any skin condition

☐ Any skin condition

68) Cancer

☐ Cancer

69) Other condition

☐ Other condition

70) If other condition, please specify:

Vaccinations

71) Have you ever had any vaccinations or immunizations?

○ Yes

◉ No

Have you had any of the following or are you up to date (received full series, boosters, etc.) on the vaccines/immunizations for the following diseases? (Select all that apply)

If yes, please bring all records of immunizations to your pre-placement health assessment including: Hepatitis A, hepatitis B, influenza, measles, mumps, rubella, MMR, meningococcal, tetanus, diphtheria, and pertussis (Tdap), and varicella

72) Hepatitis A

☐ Hepatitis A

73) Hepatitis B

☐ Hepatitis B

74) Influenza

- [ ] Influenza

75) Measles

- [ ] Measles

76) Meningococcus

- [ ] Meningococcus

77) Mumps

- [ ] Mumps

78) Polio

- [ ] Polio

79) Rubella

- [ ] Rubella

80) Smallpox

- [ ] Smallpox

81) Tetanus and diphtheria (TD)

- [ ] Tetanus and diphtheria (TD)

82) Tetanus, diphtheria, pertussis (Tdap)

- [ ] Tetanus, diphtheria, pertussis (Tdap)

83) Varicella (chickenpox)

- [ ] Varicella (chickenpox)

TB

84) Have you received a tuberculosis skin test TST or IGRA in the last year?

- ( ) Yes
- (•) No

85) If yes, what was the result?

- ( ) Positive
- ( ) Negative
- ( ) Indeterminate
- ( ) Other
- ( ) Not applicable

86) If other test result, please explain:

Part 2 - Health and Wellness

87) How would you describe your present state of health?

- ○ Excellent
- ○ Good
- ◉ Fair
- ○ Poor

Health Concerns

88) Do you have any health concerns?

- ○ Yes
- ◉ No

89) If yes, please list health concerns:

Exercise

Exercise

90) How many days per week do you exercise for 30 minutes or more?

- ○ 0
- ◉ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

Alcohol

91) Do you drink alcoholic beverages?

- ◉ Yes
- ○ No

92) If yes, indicate the number of drinks per month:

7

Tobacco Products

93) Have you ever used tobacco products?

- ○ Yes
- ◉ No

94) If yes, please specify tobacco products:

95) Are you currently smoking cigarettes?

- ○ Yes
- ○ No

96) If yes, indicate packs per day and for how many years:

97) Are you currently smoking cigars?

- ○ Yes
- ○ No

98) If yes, indicate number of cigars per day and for how many years:

99) Are you currently smoking a pipe?

- ○ Yes
- ○ No

100) If yes, indicate pipefuls per day and for how many years:

101) Are you currently chewing tobacco?

- ○ Yes
- ○ No

102) If yes, indicate packages per day and for how many years:

Part 3 - Functional Self-Assessment

103) Have you reviewed your new job description and essential functions?

- ◉ Yes
- ○ No

104) If no, did your hiring manager review your job description and essential functions with you?

- ○ Yes
- ○ No

105) Do you have a permanent physical condition that impairs your ability to do certain activities (e.g. limited range of motion due to past injury)

- ○ Yes
- ◉ No

106) If yes, please explain permanent physical condition:

Do you have decreased function in any of the following? (Select all that apply)

107) Either arm/hand, including grip/reach, use of fingers

- ☐ Either arm/hand, including grip/reach, use of fingers

108) Neck or lower back (such as arthritis or pinched nerve)

- ☐ Neck or lower back (such as arthritis or pinched nerve)

109) Hips, knees, ankles, or feet

- ☐ Hips, knees, ankles, or feet

Do you have decreased ability in any of the following? (Select all that apply)

110) To stay awake or maintain consciousness (due to such causes as seizures, diabetes, or sleep disorder)

- ☐ To stay awake or maintain consciousness (due to such causes as seizures, diabetes, or sleep disorder)

111) To breathe or maintain endurance (due to such causes as asthma, emphysema, or angina)

- ☐ To breathe or maintain endurance (due to such causes as asthma, emphysema, or angina)

112) To fight off infection (such as immune deficiency or diabetes)

- ☐ To fight off infection (such as immune deficiency or diabetes)

Do you have any physical, mental or emotional conditions that could interfere with the following? (Select all that apply)

113) Lifting

- ☐ Lifting

114) Repetitive lifting

- ☐ Repetitive lifting

115) Repetitive motion other than lifting

- ☐ Repetitive motion other than lifting

116) Carrying

- ☐ Carrying

117) Pushing/pulling

- ☐ Pushing/pulling

118) Walking

- ☐ Walking

119) Standing

- ☐ Standing

120) Sitting

- ☐ Sitting

121) Crawling

- [ ] Crawling

122) Kneeling

- [ ] Kneeling

123) Squatting

- [ ] Squatting

124) Climbing

- [ ] Climbing

125) Reaching overhead

- [ ] Reaching overhead

126) Reaching above shoulders

- [ ] Reaching above shoulders

127) Reaching away from body

- [ ] Reaching away from body

128) No strenuous physical activity

- [ ] No strenuous physical activity

129) Operating a company motor vehicle (bike, car, truck)

- [ ] Operating a company motor vehicle (bike, car, truck)

130) Hazardous or fast moving machinery

- [ ] Hazardous or fast moving machinery

131) Height (ground level work only)

- [ ] Height (ground level work only)

132) Ladder use

- [ ] Ladder use (job specific)

133) Respirator use

- [ ] Respirator use

134) Confined space

- [ ] Confined space

135) Excessive heat

- [ ] Excessive heat

136) Excessive cold

- [ ] Excessive cold

137) Work in dusty conditions

- [ ] Work in dusty conditions

138) Work in patient care areas

- [ ] Work in patient care areas

139) Working with soaps, detergents, or solvents

- [ ] Working with soaps, detergents, or solvents

140) Using latex products

- [ ] Using latex products

141) Working rotating shifts (nights, evenings)

- [ ] Working rotating shifts (nights, evenings)

142) Working more than an 8 hour shift

- [ ] Working more than an 8 hour shift

143) Working with animals

- [ ] Working with animals

144) Working with radiation or chemotherapy agents

- [ ] Working with radiation or chemotherapy agents

145) Managing multiple tasks at one time

- [ ] Managing multiple tasks at one time

146) Working in a busy/stressful environment

- [ ] Working in a busy/stressful environment

147) Other limitation or restriction

- [ ] Other limitation or restriction

148) No limitations or restrictions

- [ ] No limitations or restrictions

149) If you selected any of the above, provide comments:

150) Do you frequently experience pain or discomfort in your lower back or have you been under a doctor's care for your back problems?

- ( ) Yes
- (•) No

151) Do you believe that you require an accommodation in order to perform your job duties?

- ( ) Yes
- (•) No

152) If yes, please explain required accommodations:

Do you use any of the following physical medical devices? (Select all that apply)

153) Contact lenses

- [ ] Contact lenses

154) Glasses

- [ ] Glasses

155) Lens implants

- [ ] Lens implants

156) Hearing aids

- [ ] Hearing aids

157) Dentures

- [ ] Dentures

158) Pacemaker

- [ ] Pacemaker

159) Defibrillator

- [ ] Defibrillator

160) Back/neck brace

- [ ] Back/neck brace

161) Cane/crutches

- [ ] Cane/crutches

162) Shoe lifts

- [ ] Shoe lifts

163) Artificial limbs

- [ ] Artificial limbs

Exposure, Ergonomic and Safety Concerns

164) Do you have any concerns regarding hazardous exposures, ergonomic, or other safety issues?

- ( ) Yes
- (•) No

165) If yes, please list concerns regarding hazardous exposures, ergonomic, or other safety issues:

Pre-existing Injuries or Illnesses

166) Have you ever been off work for more than a day because of an illness or injury related to work?

- ( ) Yes
- (•) No

167) If yes, please describe the work related injury or illness:

168) Have you ever changed jobs or work assignments because of any health problems or injuries?

- ( ) Yes
- (•) No

169) If yes, please describe health problems or injuries:

170) Please describe any health problems or injuries you have experienced connected with your present or past jobs:

171) Have you ever filed a Workers' Compensation claim?

- ○ Yes
- ◉ No

172) If yes, please describe all Workers' Compensation claims:

173) Have you ever received any disability payments or settlements for inability to work? (such as auto accidents, etc.)

- ○ Yes
- ◉ No

174) If yes, explain disability payments or settlements:

Acknowledgment

175) I hereby certify that I have carefully read the questions, that I understand them and that the information given is complete, true and accurate to the best of my knowledge. I understand that the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any of the information may be grounds for termination from this program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered. TYPE YOUR NAME BELOW. THIS CONSTITUTES AN ELECTRONIC SIGNATURE THAT IS REQUIRED BY LAW.

Shicheng Guo