



Kahu Malama Nurses, Inc.

HEALTH HISTORY QUESTIONNAIRE



Applicant/Employee Name: _____

Classification: _____

I. HISTORY – Have you ever or do you currently have any of the following conditions:

- | | | | |
|--|---|---|---|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Hypertension | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Back/Spinal Problems | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Audio/Visual Problems | <input type="checkbox"/> <input type="checkbox"/> _____ | <input type="checkbox"/> <input type="checkbox"/> _____ |

If “yes”, explain: _____

	HISTORY OF DISEASE	VACCINE	BLOOD TITRE	DATE	RESULT
Varicella (Chicken Pox)					
Rubeola (Measles)					
Rubella (German Measles)					
Mumps					
Hepatitis B	Vaccine #1				
	Vaccine #2				
	Vaccine #3				
Diphtheria Tetanus Vaccine					

(Please attach copies of results if available)

LIST DISEASES, INJURIES OR SURGICAL OPERATIONS WITHIN THE LAST TEN YEARS			
DATE	DISEASE, INJURY OR SURGERY	SEVERITY & DURATION	OUTCOME

II. CURRENT HEALTH STATUS

Are you able to:

- | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | YES | NO | | YES | NO |
| Lift, carry, push, pull, etc. light weight equipment or supplies? | <input type="checkbox"/> | <input type="checkbox"/> | See and hear computer or other types of patient monitors, patient’s physical responses or co-worker instructions? | <input type="checkbox"/> | <input type="checkbox"/> |
| Stand, walk bend or lift reasonable weight (for your height and size)? | <input type="checkbox"/> | <input type="checkbox"/> | Move quickly in an emergency? | <input type="checkbox"/> | <input type="checkbox"/> |
| Use hands, arms, back & legs freely and without restrictions? | <input type="checkbox"/> | <input type="checkbox"/> | Tolerate odors related to blood and other body fluids? | <input type="checkbox"/> | <input type="checkbox"/> |
| Complete an eight hour work shift without excessive rest periods? | <input type="checkbox"/> | <input type="checkbox"/> | Wear personal protective equipment, including mask, face protector, gown and gloves? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered NO to any of these questions, please explain: _____

	YES	NO		YES	NO
Do you have any physician-imposed activity restrictions?	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently under treatment for HIV or HBV exposure? (Medications or follow-up blood testing)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any physical condition which may limit or hinder your performance in any active hospital nursing role?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any open lesions or skin conditions on your face, neck hands, arms or other exposed parts of your body?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever or are you currently under treatment or are you currently awaiting settlement on a worker's compensation claim?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to Latex?	<input type="checkbox"/>	<input type="checkbox"/>
			Do you need any assistive devices in order to perform your job?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES any of these questions, please explain: _____

I certify that all the answers and information are correct and complete. I am in good physical and mental health, free of any communicable disease and able to meet the demands of providing patient care.

DATE SIGNATURE OF APPLICANT/EMPLOYEE

DATE SIGNATURE OF KAHU MALAMA NURSES REVIEWER

The above named individual has been examined by me and found to be in good physical and mental health, free of any communicable disease, and able to meet the demands of his/her profession at full capacity.

Comments or restrictions _____

PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

NAME (PLEASE PRINT)

ADDRESS