UPSTATE
MEDICAL UNIVERSITY

EMPLOYEE – STUDENT – VOLUNTEER ANNUAL HEALTH ASSESSMENT

LAST NAME | FIRST | MIDDLE INITIAL | EMPLOYEE ID # | DATE OF BIRTH

EMPLOYEES: JOB TITLE | DEPARTMENT | SUPERVISOR

STUDENT: PROGRAM | YEAR OF GRADUATION

The Annual Health Assessment (AHA) is required by the New York State Department of Health, which requires assessment of the health status of all personnel, to assure that personnel are free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of duties. Accordingly, this assessment is done for the purpose of determining limitations on your ability to perform your job, whether your job might present a possible risk to you or whether you might present a possible risk to patients or co-workers. **It is NOT a substitute for your complete physical/regular medical care by your personal physician.**

PLEASE RESPOND TO EACH QUESTION

1. Has your job/position changed since your last AHA? ☐No ☐Yes
   If yes, list all jobs/positions you have held since your last AHA:
2. Does your job involve direct patient contact? ☐No ☐Yes
   a. If you answered no, do you work in an area where patients may be present? ☐No ☐Yes
3. Since your last AHA, have there been:
   a. Any new medical problems: ☐No ☐Yes (explain) _____
   b. Surgery? ☐No ☐Yes (explain) _____
   c. Injuries? ☐No ☐Yes (explain) _____
      i. Was the injury work related ☐No ☐Yes
4. Do you take any medications ☐No ☐Yes (If yes, list) _____
5. Any health condition or medications that might weaken your immune system? ☐No ☐Yes(explain)
6. Any health conditions or limitations that make it difficult for you to complete your work duties? ☐No ☐Yes (explain)
7. Since your last AHA, do you have any now, or recurring: *(if you answered yes, please provide details)*
   a. Contagious infectious disease? ☐No ☐Yes _____
   b. Rash? ☐No ☐Yes _____
   c. Diarrhea? ☐No ☐Yes _____
   d. Open sores or dermatitis? ☐No ☐Yes _____
   e. Fainting spells or dizziness? ☐No ☐Yes _____
8. Have you:
   a. Persistent fevers? ☐No ☐Yes
   b. Frequent coughing? ☐No ☐Yes
   c. Coughed up blood? ☐No ☐Yes
   d. Night sweats? ☐No ☐Yes
   e. Unexplained weight loss? ☐No ☐Yes
   f. Enlarged lymph nodes? ☐No ☐Yes
9. In the past 12 months, have you lived for over 1 month in a country outside the United States? ☐No ☐Yes (explain)
10. Have you had close contact with someone who has been diagnosed with active TB without the use of respiratory protection? ☐No ☐Yes
11. Since your last AHA, have you had or developed any <u>other</u> health impairment that could impose a potential risk to patients or co-workers or that may interfere with the performance of your job duties? ☐No ☐Yes (explain)
12. In your current job, do you directly handle, transport, or work with animals? ☐No ☐Yes
13. Do you have any allergy to latex? ☐No ☐Yes
14. Do you have any known allergy to substances used regularly in the performance of your job duties? ☐No ☐Yes (explain)
15. Do you currently smoke? ☐No ☐Yes
    If yes, would you like more information to help you quit smoking? ☐Yes

Employee/Student Signature | Date | Reviewed by | Date