Providence Care

EMPLOYEE PRE-PLACEMENT HEALTH QUESTIONNAIRE

STRICTLY PERSONAL AND CONFIDENTIAL

A Pre-Placement Medical Review is a condition of employment and is used to determine whether candidates are medically fit for the position following a conditional offer of employment being extended, but before they have been placed in the position.

Intentions of The Pre-Placement Medical Assessment:

- An effort to determine if the applicant has the capacities to accomplish the specific duties of the job in keeping with the physical, environmental, and psychological demands of the position.
- Establish a baseline health status data for future comparison
- Determine pre-existing or concurrent health-related problems
- Identify any working conditions that may have an impact on the worker's health and safety
- Ensure proper placement of individuals into suitable positions without risk to the worker or coworkers.

All personal health information collected during the pre-placement assessment, and anytime thereafter, is strictly confidential and will not be disclosed or released outside of the Occupational Health Department without your written consent. From time to time certain non-medical, personal information may need to be shared with individuals (e.g. your Manager, Human Resources). It will be limited to the following:

1. Information pertaining to fitness to work and required accommodation to ensure a safe return to work or accommodation in the workplace.
2. Acknowledgement that the employee has contacted Occupational Health and/or supplied documentation if required to do so.
3. Administrative data related to sick benefits (e.g. claim status).

Contact Occupational Health Nurse for questions or concerns at OHSW@providencecare.ca or 613-544-4900, ex. 53564.

I the undersigned have read and understood the above. I have had the opportunity to ask any questions to clarify any parts of the above which have been unclear to me. I also understand that certain disclosures that are required by health care professionals (such as releasing information that may be required to avert or address a health or safety risk to me or others, or as required by law such as reporting to the Workplace Safety Insurance Board) do not require my consent.

I declare all information shared is true and accurate to the best of my knowledge.

Date:	*Year*	*Month*	*Day*	**Signature of Applicant:**

Date:	*Year*	*Month*	*Day*	**Signature of Occupational Health Nurse:**

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Employee Information

Last Name	First Name	Date Of Birth		
		Year	*Month*	*Day*
Current Home Address				
Number / Street Name / Apt./Unit		Gender		
City / Province/Territory / Postal Code		Phone Number		

Department	Start Date (yyyy/mm/dd)	☐ FT ☐ PT ☐ Casual ☐ Term	Social Insurance Number (SIN):
Position:	Shifts to be worked:		Health Card Number (HCN):

Family Physician Information

Physician Name		Clinic Name	
Address - Number	Street Name	Unit/Suite	City
Province/Territory	Postal Code	Phone Number	Fax Number

In case of emergency, please notify:

First Name:	Last Name:	Relationship:	Phone Number:

Personal Medical History

How would you describe your overall level of health?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

How would you describe your overall level of fitness?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Are you currently experiencing symptoms potentially caused by your previous work or home environment?

☐ Yes ☐ No

Please list any surgical procedures or hospitalizations and the YEAR in which they took place:

Year	Details of Surgical Procedure or Hospitalization

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Systems Review: Indicate below if you are currently or have ever been treated for any of the following conditions. On the next page, please provide details for each item that you have answered "Yes."

Allergies	Yes	No
Drugs/ Medications	☐	☐
Food	☐	☐
Insect Venom (Bees)	☐	☐
Environmental	☐	☐
Pet Dander	☐	☐
Latex	☐	☐
Chemicals/ Perfume	☐	☐
Other (specify):	☐	☐

Skin Disorders	Yes	No
Psoriasis	☐	☐
Eczema	☐	☐
Atopic Dermatitis	☐	☐
Rosacea	☐	☐
Other (specify):	☐	☐

Neurological	Yes	No
Seizure Disorder	☐	☐
Headache/ Migraine	☐	☐
Concussion	☐	☐
Stroke	☐	☐
Neurodevelopmental: Autism/ ADHD, etc.	☐	☐
Other (specify):	☐	☐

Ears/ Nose/Throat	Yes	No
Eye/ Visual problems	☐	☐
Ear/ Hearing problems	☐	☐
Nose (Allergic Rhinitis, epistaxis etc.)	☐	☐
Other (specify):	☐	☐

Psychological	Yes	No
Anxiety	☐	☐
Depression	☐	☐
Bipolar Affective Disorder	☐	☐
Schizophrenia	☐	☐
Addiction	☐	☐
Other DSM-V (Specify):	☐	☐

Cardiovascular	Yes	No
Blood Pressure abnormalities	☐	☐
Coronary Artery Disease	☐	☐
Aortic Dissection	☐	☐
Angina	☐	☐
Congenital Heart Disease	☐	☐
Arrhythmia	☐	☐
Tachycardia	☐	☐
Other (specify):	☐	☐

Respiratory	Yes	No
Asthma	☐	☐
COPD	☐	☐
Sarcoidosis	☐	☐
Pulmonary Hypertension	☐	☐
Cystic Fibrosis	☐	☐
Bronchiolitis	☐	☐
Other (specify):	☐	☐

Rheumatology	Yes	No
Systemic Lupus	☐	☐
Myasthenia Gravis	☐	☐
Rheumatoid Arthritis	☐	☐
Inflammatory Bowel Disease (Crohn's)	☐	☐
Multiple Sclerosis	☐	☐
Fibromyalgia	☐	☐
Other (specify):	☐	☐

Gastrointestinal	Yes	No
GERD (heartburn) or Peptic Ulcers	☐	☐
Irritable Bowel	☐	☐
Colitis	☐	☐
Inguinal Hernia	☐	☐
Diverticulitis	☐	☐
Celiac	☐	☐
Gallstones	☐	☐
Other (specify):	☐	☐

Musculoskeletal	Yes	No
Tendinitis	☐	☐
Carpal Tunnel	☐	☐
Osteoarthritis	☐	☐
Chronic Pain	☐	☐
Scoliosis	☐	☐
Herniated disc	☐	☐
Fractures	☐	☐
Amputations	☐	☐
Other (specify):	☐	☐

Hematology	Yes	No
Anemia	☐	☐
Hemochromatosis	☐	☐
Coagulation disorders (bleeding disorders)	☐	☐
Other (specify):	☐	☐

Endocrine	Yes	No
Diabetes	☐	☐
Adrenal insufficiency	☐	☐
Thyroid Concerns	☐	☐
Other (specify):	☐	☐

Genitourinary	Yes	No
UTIs or other bladder concerns	☐	☐
Kidney disease	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Benign Prostatic Hypertrophy	☐	☐
Other (specify):	☐	☐

Infectious	Yes	No
Hepatitis (A/B/C)	☐	☐
Tuberculosis	☐	☐
HIV	☐	☐
C-difficile	☐	☐
Other (specify):	☐	☐

OTHER	Yes	No
Cancers/ Tumors	☐	☐

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Systems Reviewed Continued
Please provide further detail for each item that you answered 'YES' to on the previous page: Occupational Health Nurse Comments:
Please list any medications, including "over the counter" preparations, vitamins or herbal remedies, or medical cannabis, (dosage & frequency) that you take on a regular basis. Occupational Health Nurse Comments:
Please list conditions that are being treated by a Health Care Professional. Occupational Health Nurse Comments:

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Personal Medical History	Yes	No
Do you currently smoke? If yes, please indicate number/day_____ OR _____ packs/day.	☐	☐
Did you previously smoke? If yes, number of years quit _____ OR months quit _____.	☐	☐
Are you interested in information about quitting smoking?	☐	☐
Is there any medical reason preventing you from having a driver's license? If yes, please provide details:	☐	☐
Frequent hand washing is a requirement for many positions in the hospital. Have you any restrictions or special needs related to hand washing and the use of alcohol based hand sanitizer or disinfectants? If yes, please provide details:	☐	☐
Have you ever been advised to change jobs/duties because of a health problem or injury or required work restrictions related to a health problem? If yes, please provide details:	☐	☐
Have you a disability or medical condition that may require an individual emergency plan or Emergency Response Procedures? If yes, please explain your Emergency Response needs:	☐	☐
Do you have any other health concerns you wish to discuss with the Occupational Health Nurse?	☐	☐

I am aware of the essential duties of this position and do not have any restrictions which prevent me from performing the essential duties of this position. I declare that all answers on this pre-placement health assessment to the best of my knowledge are accurate and complete. I understand that any misrepresentations about my own personal health on this preplacement health review is just cause for discipline up to and including termination.

Date:	*Year*	*Month*	*Day*	**Signature of Applicant:**

Date:	*Year*	*Month*	*Day*	**Signature of Occupational Health Nurse:**