Kaiser Permanente South Bay Medical Center – Employee Health Services

INTERVAL HEALTH EVALUATION QUESTIONNAIRE

ATTENTION STUDENTS & FACULTY: Complete this form and submit to EHS if the student/faculty has a **HISTORY OF POSITIVE PPD**.
Complete this form, submit to EHS, and have a PPD done if the student/faculty has a **HISTORY OF NEGATIVE PPD**.

Name:____ Date of Birth:______________________________

Age: __________ Sex: ________________ Phone ________________________ Email ______________________________

School:____ Unit/Department:____________________________

Read the following carefully! All questions must be answered by all students/faculty whether they have a (-) or (+) PPD.

	YES	NO	QUESTION
1			Have you changed your last name since last year? If "Yes", give old:_______________new:____________
2			Have you had any new problem, which currently is infectious or would prevent you from performing your assigned duties at this time? If "Yes", please describe:
3			Have you had an unexplained weight loss in the last year? If "Yes", give amount lost:
4			Do you have a persistent cough lasting 3 weeks or more?
5			Do you cough up blood?
6			Do you have persistent, unexplained fevers or night sweats?
7			Do you have a rash? If "Yes", for how long?
8			Have you seen a doctor for any of the above? If "Yes", which numbered item?
9			Do you have any reason to believe that your immune system may have been altered or damaged due to any of the following conditions or medications, which could increase your risk for tuberculosis (i.e. cancer; sarcoidosis; HIV/AIDS; chemotherapy; chronic steroid therapy or medications to prevent transplant rejection) ? ***Note: HIV infection and other medical conditions may cause a TB (PPD) skin test to be negative even when TB infection is present.***
10			If you have a positive TB test, do you also have any one of the following conditions (*you do not have to divulge your medical diagnosis):* part of your stomach removed, underweight/malnourished, infection with the AIDS virus or at risk for it, diabetes, silicosis lung disease, leukemia or lymphoma, kidney failure, head/neck cancer?
11			Have you completed the hepatitis B vaccine series? If "Yes" How many shots have you had? **HEPATITIS B VACCINE DECLINATION** ☐ I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me. Sign below if you want to decline the Hepatitis B vaccine. ______________________________ ____________ Signature Date
12			Do you give/mix IV cytoxin (chemotherapy) drugs as part of your work assignment? If "Yes" How often?
13			Do you work with lasers? If "Yes" What type?
14			Have you had any skin or other reaction after contact with latex gloves or other latex products? If "Yes", have you been provided effective alternates to those products?: ☐ Yes ☐ No ***If you have any questions about hand care or latex allergies, please contact Employee Health Services.***

______________________ ______________________ ______________________
NAME SIGNATURE DATE

EHS Staff/Licensed Provider Reviewer Name & Title	EHS Staff/Licensed Provider Reviewer Signature	Date