Stony Brook Medicine

Employee Health and Wellness
University Hospital, Level 8S, Rm 140
Stony Brook, NY 11794-7080
P: 631-444-7767 F: 631-444-6199

Pre-Placement Physical

Welcome to Stony Brook University Hospital (SBUH). To be in compliance with New York State Public Health Code Title 10, 405.3, SBUH Policy, and relevant OSHA and NYSDOH regulations, medical requirements for employment/staff privileges shall include, at minimum:

- ❑ 1. Medical History
- ❑ 2. Physical Examination by licensed health practitioner
- ❑ 3. Compliance with TB control program, including REQUIRED two step PPD skin testing (or Quantiferon Gold/T-Spot blood test within 3 months of hire date), symptom review, and chest x-ray, if indicated.
- ❑ 4. Medical clearance for respirator wear (if designated by the department).
- ❑ 5. Documentation of immunity or vaccination against Rubella, Measles, and Mumps.
- ❑ 6. Documentation of varicella (chicken pox) immunity.
- ❑ 7. Documentation of vaccination against Hepatitis B or signed declination.
- ❑ 8. Documentation of completed COVID-19 vaccination series.

Legal Name (print): ____
Last First MI

Preferred Name (print): ____

E-Mail: ______________________________ Cell Phone: ( ) ________________

Date of Birth: ____________________ Place of Birth: ______________________

Mailing Address: ______________________________ Phone: ( ) ____________

Have you lived outside of the U.S.? ❑ Yes ❑ No If yes, specify dates and location:

____

Emergency Contact: ________________ Relationship: __________ Phone: ( ) ____________

Supervisor's Name: ______________________________ Phone: ( ) ____________

Your Department: __________________ Job Title: ____________ Phone: ( ) ____________

I understand that Stony Brook University Hospital is a **smoke free environment**. ______________________
Signature

REQUIRED: Please attach lab report of antibody titers and vaccine documentation

Yes No
❑ ❑ 1. Varicella (Chicken Pox): Lab report of positive titer or documentation of 2 dose series of varicella vaccine.
❑ ❑ 2. Measles (Rubeola): Lab report of positive antibody titer OR documentation of 2 doses of MMR vaccine required.
❑ ❑ 3. Mumps: Lab report of positive antibody titer OR documentation of 2 doses of MMR vaccine required.
❑ ❑ 4. Rubella (German measles): Lab report of positive antibody titer OR documentation of 1 dose of MMR vaccine required.
❑ ❑ 5. Hepatitis B: Documentation of 3 dose series of Hepatitis B vaccine or signed Hepatitis B declination page is required. Please attach lab report of post-vaccination Hep B surface antibody titer if available.
❑ ❑ 6. **RECOMMENDED**: Tetanus (Td or Tdap) vaccine within 10 years: please attach documentation.
❑ ❑ 7. For food service 2 doses Hepatitus A.
❑ ❑ 8. COVID: Fully vaccinated for COVID-19.

Stony Brook Medicine

Part A -- Health History
To be completed by the patient.

Legal Name (print):________________________________ Preferred Name (print):____________________________

Medical History and Review of Systems:

Have you ever had or do you have any of the following?

Infectious Diseases	Yes	No
Chicken Pox or Shingles		
Measles		
Mumps		
Tuberculosis or positive IGRA or PPD test		
Other Disease:		
Respiratory/Lungs		
Chronic Bronchitis/Emphysema/COPD		
Asthma/Wheezing		
Asbestosis, Silicosis, Pneumoconiosis		
Pneumonia		
Pneumothorax (collapsed lung)		
Broken ribs or chest injury/surgery		
Coughing up phlegm or blood		
Shortness of breath or chest tightness		
Cardiovascular/Heart		
Heart Attack		
Chest pain/Angina		
Heart failure		
Irregular heart rhythm or palpitations		
High blood pressure		
Edema (swelling of legs/feet)		
Stroke		
Neurologic		
Seizures or Epilepsy		
Numbness, weakness or paralysis of arms or legs		
Head injury or concussion		
Severe headaches or migraines		
Dizziness or fainting spells		
Other neurologic disorder		
Sleep apnea or other sleeping disorder		

Gastrointestinal and Kidney	Yes	No
Stomach or intestinal problem		
Hepatitis or other liver disease		
Kidney disease or kidney stones		
Hernia		
Blood in urine		
Skin, Endocrine, Severe Allergic Reaction		
Chronic rash or eczema		
Diabetes		
Thyroid or other endocrine problem		
Allergic reactions that affect breathing		
Vision and Hearing		
Wear glasses or contacts		
Eye disorder (e.g. glaucoma, macular degeneration, cataracts, etc.) or injury		
Color blindness		
Hearing loss or tinnitus (ringing in ears)		
Musculoskeletal		
Back/neck injury or pain		
Arthritis/gout		
Other bone/joint problem or injury- please specify:		
Miscellaneous		
Anemia		
Cancer		
Immune system disorder		
Bleeding or clotting disorder		
Trouble smelling odors		
Claustrophobia or anxiety		
Psychiatric illness (e.g. depression, bipolar)		
Surgeries or hospitalizations		
Reason:		

Please provide details, including dates, for any items marked yes above. Please note any other medical conditions not listed above. _______________

Medications: Please list your current medications (prescription and over the counter, including vitamins/supplements): ______________________

Allergies: please specify	Yes	No
Medications:		
Latex		
Other (e.g. foods, animals, etc.):		

Stony Brook Medicine

Part A -- Health History

To be completed by the patient.

Legal Name (print):________________________________ Preferred Name (print):_________________________

Social and Work-Related Health History:

Social History	Yes	No
Alcohol Use (Circle # of Drinks per Week): None 1 to 5 6 to 14 15 or more		
Tobacco Use (Circle one): Never Former Current (specify #packs/day and #years):		
Do you use any other substances or recreational/street drugs?		
Have you ever received treatment for substance use or abuse?		
Work-Related Health History	**Yes**	**No**
Have you ever used a respirator? Please specify type:		
Have you ever experienced any problems when wearing a respirator?		
Have you ever been refused employment for health reasons or had to leave a job for health issues?		
Do you have visual, hearing or other physical limitations? Please specify:		
Do you have any conditions or disabilities that may prevent you from performing the essential functions of your job or which require accommodation? Please specify:		
Have you ever had a work-related injury or illness? Please specify:		

Tuberculosis (Tb) Screening:

Symptom Review: Fever, sweats, cough, weight loss or hemoptysis (spitting up blood): □ Yes (circle all that apply) □ No

If History of Positive Screening Test: If you have ever had a positive PPD or Quantiferon/T-Spot test, one chest x-ray is REQUIRED. (No additional PPD or blood test needed). Please complete the information below:

Date of positive PPD or blood test:_____/_____/_____ Chest x-ray date: _____/_____/_____ (Must attach x-ray report)

Treated with INH: □ Yes, for ____ months □ No History of BCG Vaccine: □ Yes □ No

If NO History of Positive Screening Test: A two-step PPD test is required. The two PPD tests must be at least one week apart but not greater than 12 months apart. The most recent test must be within the last 3 months. Lab report of a negative Quantiferon Gold or T-Spot test within the last 3 months may be submitted in place of the two step PPD.

I certify that the information on this form is correct and complete to the best of my knowledge. I further understand that the results of this examination will be used to identify any medical condition(s) which might interfere with my ability to perform work duties. My employer will be made aware only of my fitness status. I also certify that I am free from habituation or addiction to alcohol, drugs or other substances which may alter behavior or affect my ability to perform work-related duties.

_____________________________________ _____________________

Employee Signature Date

To be completed by healthcare provider. PPDs must be read by an Attending Physician, NP or PA. Self-reading is not acceptable

1.) Date placed: ____/____/____ Manufacturer_____________ Lot# __________ Exp. Date ____/____/____

Date read: ____/____/____ Result Neg_____mm Pos______mm

Signature: _____________________ Print Name ______________________ License #_____________

2.) Date placed: ____/____/____ Manufacturer_____________ Lot# __________ Exp. Date ____/____/____

Date read: ____/____/____ Result Neg_____mm Pos______mm

Signature: _____________________ Print Name ______________________ License #_____________

OR □ I am submitting a Quantiferon Gold/T-spot lab report in place of two-step PPD

Part B -- Physical Exam

To be completed by healthcare provider.

Legal Name (print):____________________

Pre-Placement Physical

Pulse: ____________ **Blood Pressure:** ____________ **Height:** ____________ **Weight:** ____________

Ishihara Color Test__________ **Pass** ❑ **Fail** ❑

	Within Normal Limits	Abnormal
General Appearance		
Mental Status		
Skin		
Nodes		
Eyes		
Ears, Nose, Oral Cavity, Throat		
Neck, Thyroid		
Heart		
Chest, Lungs		
Abdominal		
Extremities		
Neurologic		
Spine/Back		
Others		

Please explain any abnormal findings: ____________________

____

Note any recommended limitations or accommodations: ____________________

____

A. Mandatory medical clearance for N95 respirator use is required for all employees with patient care contact. After physical exam and review of medical history, I find the above named fit for respirator use:

❑ Yes ❑ No ❑ Fit with restrictions: ____________________

B. After physical examination and review of past medical history, I find the above named to be free from health impairment which might interfere with the performance of his/her duties as required by NEW YORK Health Code (Title 10, Section 405.3).

____________________ ____________________

Signature of Examining MD, DO, PA, or NP Date

____________________ ____________________

Print Name of Examining MD, DO, PA, or NP Lisc. # & Issuing State

C. Upon review of past medical history, vaccination records and/or titer results, I find the above named free from Tuberculosis and to show immunity to Rubella and Rubeola as required by New York State Health Code (Title 10, Section 405.3). As per SBUH Policy HR008 the above named shows immunity to Mumps.

____________________ ____________________

Signature of Examining MD, DO, PA, or NP Date

____________________ ____________________

Print Name of Examining MD, DO, PA, or NP Lisc. # & Issuing State