

**Preplacement Screening Patient Contact Form
UF Employee/Volunteer**

Name: _____ **UFID:** _____

Patient Contact Review appointments must be scheduled. There are NO Patient Contact Review appointments on Thursdays. These may be scheduled at either the main SHCC or SHCC @ Shands.

[Student Health Care Center at Shands](#)- Occupational Medicine Clinic
352-392-1161 ext 1-4212 or ext 1-4391

[Main Student Health Care Center](#)
352-392-0627

The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job. Medical History information on this form will be kept in a confidential file at the SHCC, and will not be shared with your Employer, Program or Director without your written permission/consent. Immunization Documentation may be shared with your Program and the Occupational Medicine Department of your work site.

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm / dd / yy)

UF ID#: _____ **SS#:** _____

Work Site - Gainesville: _____ **Jacksonville:** _____ **Other:** _____

Position Number: _____ **Job Title:** _____

Department: _____ **Supervisor/Prog Director:** _____

Section I - Medical History

Do you have now, have you ever had, or have you received treatment for the following:

Yes	No		If YES use as many lines below as needed to explain
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgeries	_____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medications/foods	_____
<input type="checkbox"/>	<input type="checkbox"/>	Current Medications: doses and Frequency	_____
<input type="checkbox"/>	<input type="checkbox"/>	Visual loss (one or both eyes)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty hearing/hearing aides	_____
<input type="checkbox"/>	<input type="checkbox"/>	Deafness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Allergic rhinitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type)	_____

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- | | | | |
|--------------------------|--------------------------|----------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Other liver disease (type) | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (type) | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Carpal tunnel syndrome | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other hand/wrist problems | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Back or neck injury | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic back pain | _____ |

- | Yes | No | | If <i>YES</i> use as many lines below as needed to explain |
|--------------------------|--------------------------|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Disc problems or sciatica | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Limited activities due to back or neck injury or pain | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol abuse/alcoholism | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug abuse/addiction | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppression | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex allergy or other skin sensitivities | _____ |

Have you ever had a work-related illness or injury? Yes ___ No ___

If yes, explain: _____

Are you currently recovering from any significant illness or injury? Yes ___ No ___

If yes, explain: _____

Do you have any medical or psychological conditions that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/request any modifications to your job duties? Yes ___ No ___ If yes, explain: _____

Would you like to speak to a UF Student Health / Occupational Medicine clinician about any of the information you have given above? Yes ___ No ___ If yes, daytime phone (_____) _____

How may we contact you if we need more information?

E-mail address: _____ **Phone#:** _____

Mailing Address: _____

Other #s: _____

Signature: _____ Date: _____

