



New Employee Registration and Health History Form

CONFIDENTIALITY STATEMENT: This form requires that you provide personal health information that is protected by University policy and State and Federal law. Your rights to the confidentiality of your personal health information will be strictly maintained by Employee Health Services. Your information will be used or disclosed in accordance with those policies and laws only to the minimal extent necessary for your treatment or business operations. You have the option of sending the form via regular mail or sending it via interoffice mail to the address above.

Date: _____

Last Name: _____ First Name: _____ Mi: _____ Suffix: _____

Date of Birth: _____ Gender: Male Female

Phone: _____ Mobile: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Job Title: _____ Department: _____

Immunization Questions

What was the approximate date of your last Tetanus booster? _____

What was the approximate date of your last Measles booster? _____

TB Screening Questions: circle yes or no

Yes No Have you ever had a **positive** TB skin test? If yes, when? _____

Yes No Have you ever taken medicine in follow-up of a positive TB skin Test?

Bloodborne Pathogen Exposure Questions: circle yes or no

Yes No In your job here at The University of Texas, will you be exposed to blood and bodily fluids?

Yes No Have you ever received the full series (3 shots) of Hepatitis B vaccine?

Yes No If you are a risk of being exposed to Hepatitis B, while performing your job here at the Univeristy; do you want the vaccine series?

If you will be exposed to bloodborne pathogens in your job here at The Univeristy of Texas we will provide the Hepatitis B vaccine series to you at no charge.

If you will be exposed to blood and bodily fluid and **choose not to accept the vaccine**, please read and sign the statement below:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at this time. I understand that be declining this vaccine, I continue to be at risk of acquiring Hepatitis B infection, a serious disease. If in the future I continue to have occupational exposure to blood or tohter potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

Employee Signature

Date

Past History and Review of Systems: Please check the problem if you have ever had any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Skin Problems. | <input type="checkbox"/> Diabetes/Sugar disorders |
| <input type="checkbox"/> Communicable Diseases. | <input type="checkbox"/> Neck/back/knee problems |
| <input type="checkbox"/> Persistent or unusual cough. | <input type="checkbox"/> Difficulty with ears or hearing loss |
| <input type="checkbox"/> Tuberculosis, BCG vaccine or a positive TB skin test. | <input type="checkbox"/> Color blindness/vision problems |
| <input type="checkbox"/> Loss of consciousness/seizures/ convulsions | <input type="checkbox"/> Alcohol/drug treatment/drunk driving arrest |
| <input type="checkbox"/> Unsteadiness in balance/dizzy spells | <input type="checkbox"/> Psychiatric/emotional problems/depression/anxiety |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Immunization dates: Tetanus _____ |
| <input type="checkbox"/> Sexually transmitted diseases | Hepatitis B _____ |
| | MMR _____ |

Comments: _____

Office Use Only

TB Booster: _____ MMR Booster: _____

TB Skin test given: Date: _____ TB skin test result _____ mm Date of reading: _____

Sent for CXR: Date: _____ Result _____

Hepatitis B vaccine: #1 _____ #2 _____ #3 _____