MERCYONE

MercyOne North Iowa Occupational Health
Chesiea Creek Building | 1501 4th ST SW
Mason City, IA 50401
Phone: 641-428-5287 | Fax: 641-428-5765
mchlthwk@mercyhealth.corn

DATE/TIME: _____

2023 SCREENING
PLEASE PRINT CLEARLY

NAME: _____
(FIRST) (MIDDLE INITIAL) (LAST)

Maiden Name (if any): _____

DATE OF BIRTH: ____/____/____

SOCIAL SECURITY# _____

DRIVER'S LICENSE#_____

PHONE # _____

ADDRESS: _____

CITY: _____STATE: _____**ZIP:** _____

PERSONAL EMAIL:_____

EMPLOYER / RESPONSIBLE PARTY: _____
(Company that sent you here)

STAFF USE ONLY:
Faxed/Emailed:_____
Date Completed:_____
Staff Initial:_____

Consent to Medical Treatment

I consent to medical treatment from MercyOne North Iowa and/or clinic medical providers and staff consulted for my care and treatment. Consults may be in person, by telephone, telemedicine or other electronic technologies. I consent to care and services provided by MercyOne and contracted staff. The care may include prevention, physical examination, treatment, tests, procedures, and routine nursing care. I give my permission to photograph any or all of my body for medical purposes only knowing that they will not be shared with anyone unless needed for continuum of care. Tests for blood borne diseases will be performed at no cost to me if someone is exposed to my blood, including the HIV test.

Personal Belongings

I understand I should send my valuables home, or I should ask to store them in a secure location. I understand MercyOne is not responsible for loss or damage to the valuables I keep with me. I understand the MercyOne employees have a right to search belongings, my visitors, or me at any time for the safety of others and me. I understand no one can have illegal drugs, alcoholic beverages, toxic substances, dangerous articles, or weapons. If someone has these items, I understand the person may be arrested and/or discharged from MercyOne medical services.

Initials _____, I understand I am responsible for the security of my valuables while I am here and, I have been offered the following:

- Providers Notice of Privacy Practice
- Methods to report concerns related to care, treatment, services, and patient safety issues
- Patient rights information

I had the opportunity to ask questions and I received answers to my satisfaction.

Signature of Patient: Date: _____Time_____

Witness to Signature: Date: _____Time_____

Signature of person with legal authority if patient is unable to sign or is a minor. Relationship Date Time

Label or Patient First, MI, Last Name

_____

DOB: ___/___/___MR#:_____

MERCYONE

Have you had the Covid-19 Vaccine? **Yes** _____ **No** _____

If NO have you applied for an exemption? **Yes** _____ **No** _____

Section 1: Person to Receive Vaccine (please print)

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH month_____ day_____ year _____
PATIENT/COLLEAGUE ID	STATE	ZIP		PHYSICIAN NAME

Section 2: Screening for Vaccine Eligibility

The following questions will help us determine if there is any reason we should not give you inactivated injectable influenza vaccine today. If you answer "yes" to any question, it may mean you should not be vaccinated. It means additional questions may be asked. If a question is not clear, please ask your healthcare provider for clarification.

Screening Questions	YES	NO
1. Are you sick today?	☐	☐
2. Do you have an allergy to eggs, eggs products or any other component of the vaccine? If yes, please list: _____	☐	☐
3. Have you ever had a serious reaction to influenza vaccine in the past?	☐	☐
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?	☐	☐

Section 3: Colleague and Healthworks Patients Only:

I have read or had explained to me the 2022-2023 Vaccine Information Statement for the seasonal influenza vaccine and agree to receive this vaccine.

_____Date _____Time _____

Signature of Colleague, Patient, Guardian or Person (below) who has legal authority if patient is unable to sign or is a minor.

Relationship to Patient _____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Colleague Vaccine	Route	Date Dose Administered	Vaccine	Lot	Person administering vaccine name / credentials
Influenza	☐ IM R / L	/ /	Fluarix GSK	Lot # 93372 Exp. 6/30/2023	

Clinic Patient / Colleague Vaccine	Route	Date Dose Administered	Manufacturer	Number	Person administering vaccine name / credentials
Influenza	☐ IM R / L	/ /			

Entered into IRIS ____Yes Date_____ **Employee Health only** – entered into Workday ___Yes Date_____

HAVE YOU HAD YOUR FLU SHOT THIS YEAR??
YES OR NO

SEASONAL INFLUENZA VACCINE RECORD
MercyOne Medical Group - North Iowa
MH-518 (09/22) Medical Record–Clinic

Label or Patient First, MI, Last Name
_____
DOB: ___/___/____MR#:_____

MERCYONE

MercyOne North Iowa Medical Center
1000 4th Street SW
Mason City, IA 50401

T 641-428-7000
F 641-428-7827

MercyOne.org

Authorization to Release Information

I authorize the release of the results of the physical examination to MercyOne North Iowa Medical Center and/or MercyOne New Hampton Hospital. I also authorize the results of the drug screen, if negative, be released to MercyOne North Iowa Medical Center and MercyOne New Hampton Hospital; if non-negative, be released to Medical Review Officer (MRO) designated on the drug testing chain of custody form (COC). By this authorization, I do hereby release, to the extent permitted by law, the laboratory performing the testing, the doctor, medical personnel, hospital, medical center, clinic, MercyOne North Iowa Medical Center, MercyOne New Hampton Hospital or any of its representatives from any and all liabilities arising from the release or use of the information derived form or contained in the physical examination and test results.

Patient (Print Name): _____

Patient Signature: _____ Date: _____

Latex Sensitivity Downtime Form

1. Have you ever been told by a health provider that you have an allergy to any latex (rubber) product?

☐ YES ☐ NO

If yes, were you tested for a latex allergy? Results: _____

2. Have you ever had a reaction to any of the following latex (rubber) products?

☐ YES ☐ NO (If yes, please circle below)

Ace bandages	Adhesive tape	Balloons	Belts
Brassieres	Condoms	Corsets	Erasers
Face masks	Garden hoses	Golf or tennis grips	
IV tubing	Pacifiers	Rubber bands	Rubber gloves
Shoe wear	Suspenders	Teething rings	

3. Do you have any food allergies? ☐ YES ☐ NO

(If yes, are you allergic to any of the following? Please circle the ones you've reacted to)

Apples	Apricots	Avocados	Bananas
Carrots	Celery	Chestnuts	Figs
Grapes	Hazelnuts	Kiwis	Melons
Nectarines	Passion fruit	Peaches	Pears
Pineapples	Plums	Potatoes	Rye wheat
Tomatoes	Other(s): _____		

Name: _____
DOB: _____
Employer: _____

Label or Patient First, MI, Last Name

_____

DOB: ___/___/_____MR#:_____

MercyOne North Iowa
Occupational Health
1501 4th St. SW
Mason City, IA 50401
Phone: 1-641-428-5244

Basic Health Physical

Employer:_____ Employee Job Title: _____

OCCUPATIONAL HISTORY:

(Please report past work history below) (Check √ if your previous work has involved exposure to the following):

Employer (Start with most recent job)	Type of Work	No. of Years	Asbestos	Chemicals or Solvents	Fumes Dusts (Metal Welding)	Vibration or Repetitive Work	Radiation	Blood or Body Fluids	Noise
1.			☐	☐	☐	☐	☐	☐	☐
2.			☐	☐	☐	☐	☐	☐	☐
3.			☐	☐	☐	☐	☐	☐	☐
4.			☐	☐	☐	☐	☐	☐	☐

TO BE COMPLETED BY PROSPECTIVE EMPLOYEE **PRIOR** TO APPOINTMENT: Check YES or NO

Do you EVER have	**Y**	**N**	**Have you EVER had**	**Y**	**N**	**Have you EVER had**	**Y**	**N**
Reaction to medication	☐	☐	Fits or convulsions	☐	☐	Blood in urine	☐	☐
Reaction to chemicals	☐	☐	Epilepsy or seizures	☐	☐	Kidney trouble	☐	☐
Skin rashes or eczema	☐	☐	Paralysis	☐	☐	Trouble with urination	☐	☐
Have you EVER had			Numbness in hands or feet	☐	☐	**Have you EVER had**		
Hay fever or allergies	☐	☐	Double vision	☐	☐	Liver trouble	☐	☐
Shortness of breath w/ walking	☐	☐	Severe or disabling headaches	☐	☐	Hepatitis or jaundice	☐	☐
Tightness in chest	☐	☐	Dizzy spells	☐	☐	**Do you have**		
Tuberculosis	☐	☐	Nervous breakdowns	☐	☐	Diabetes	☐	☐
Emphysema or COPD	☐	☐	**Have you EVER had**			Thyroid problem or goiter	☐	☐
Problem working in dusty jobs	☐	☐	Back injury	☐	☐	Problem with anemia	☐	☐

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Do you	**Y**	**N**	Back pain for more than 1-2 days per month			Problem where you bleed easily		
Smoke cigarettes _____pk/day X _____yrs			Back surgery			**Have you EVER**	**Y**	**N**
Use other form of tobacco			Ruptured or herniated disk			Been treated with radiation		
Have you EVER had			Knee or hip surgery			Worked with radioactive material		
High blood pressure			Swollen joints			**ARE or DO you**		
Heart problem			Dislocated shoulder			Taking any medicine regularly		
Heart attack			Rheumatism or arthritis			Using any illegal drugs		
Heart surgery (bypass, stent)			Fracture of bone			Use alcohol regularly		
Swelling in ankles			**Do you use**	**Y**	**N**	How much? _____		
Fainting spells/passed out			Glasses or contacts for reading			How often?_____		
Varicose veins			Glasses or contacts for distance			**Have you EVER had**		
Do you have			**Did you EVER have**			Restrictions of any kind at a previous job		
Stomach ulcer			Ear surgery			Any medical condition aggravated by work or job?		
Frequent nausea			Difficulty hearing			Hepatitis shot series		
Frequent bowel trouble			Any other trouble			Date of last tetanus shot? _____(MM/YYYY)		
Frequent diarrhea			Do you wear hearing aids					
Hernia			Ringing in ears					
How often do you exercise?		Not at all		1-2 times/week		3-4 times/week		Daily

Explanation of all "Y" answers:

_____

_____

_____

Current Medications (prescriptions and over the counter):

_____

_____

_____

EMPLOYEE PLEASE READ AND SIGN & DATE

The information I have given is true to the best of my knowledge and belief. I understand that any intentional misrepresentation or omission of fact will justify rejection of my application for employment or termination of my employment. I hereby authorize any physician or medical person who has attended me to make disclosure to HealthWorks medical information concerning my medical history.

_____ _____ _____

Signature Printed Name Date

Label or Patient First, MI, Last Name

_____

DOB: ___/___/___MR#:_____

MercyOne North Iowa
Occupational Health
1501 4th St. SW
Mason City, IA 50401
Phone: 1-641-428-5244

OSHA Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in section 1, and to questions 9 & 10 in Section 2 of Part A, do not require a medical examination.		
To the employee:	YES	NO
Can you read? (check one)	☐	☐
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will receive it.		

Part A. Section 1. (Mandatory) **Every employee who has been selected to use any type of respirator must provide the following information (please print).**		
1. Today's Date:	2. Your Name:	
3. Your age:	4. Sex: ☐ Male ☐ Female	
5. Your height: ft. in.	6. Your weight: lbs.	
7. Your job title:	8. Your employer:	
9. Phone number where you can be reached: (___) ___ -- ____		
10. Best time to phone you at this number:		
	YES	NO
11. Has your employer told you how to contact the health care professional who will review this questionnaire?	☐	☐
12. Check the type of respirator you will use: (you can check more than one category) ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only) ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied air, self- contained breathing apparatus)		
13. Have you worn a respirator: (check one) If yes, what type(s):	☐	☐

Part A. Section 2. (Mandatory) **Every employee who has been selected to use any type of respirator must, according to OSHA regulations, provide us with the following information.**		
Please check one:	YES	NO
1. Do you CURRENTLY smoke tobacco, or have you smoked tobacco in the last month? If yes, # packs per day _____, # of years _____, ☐ Cigarettes, ☐ Cigars, ☐ Pipe	☐	☐
2. Have you EVER had any of the following conditions?		
a. Seizures (fits)	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors	☐	☐

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3. Have you EVER had any of the following pulmonary or lung problems?	YES	NO
a. Tuberculosis	☐	☐
b. Silicosis	☐	☐
c. Pneumothorax (collapsed lung)	☐	☐
d. Lung cancer	☐	☐
e. Broken ribs	☐	☐
f. Any chest injuries or surgeries (please explain)	☐	☐
g. Any other lung problems that you've been told about (please explain)	☐	☐
4. Do you CURRENTLY have any of the following symptoms of pulmonary or lung illness?	**YES**	**NO**
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems:	☐	☐
5. Have you EVER had any of the following cardiovascular or heart problems?	**YES**	**NO**
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia	☐	☐
g. High blood pressure	☐	☐
h. Frequent pain or tightness in your chest	☐	☐
i. Pain or tightness in your chest during physical activity	☐	☐
j. Pain or tightness in your chest that interferes with your job	☐	☐
k. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
l. Heartburn or indigestion that is not related to eating	☐	☐
m. Any other symptoms that you think may be related to heart problems:	☐	☐
6. Do you CURRENTLY take medications for any of the following problems?	**YES**	**NO**
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures	☐	☐
7. If you've used a respirator have you EVER had any of the following problems? (If you have never used a respirator, mark N/A in the following spaces and proceed to #8)		
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety or claustrophobia	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problems that interferes with the use of a respirator:	☐	☐
8. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐	☐
9. Have you had a respirator fit test in the past year?	☐	☐

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_____

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Please explain all YES responses: Number:	Explanation

Questions 11 to 16 below must be answered by every employee who has been selected to use either a full-face respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary. (*HealthWorks providers request that all persons wearing respirators answer these questions.)	YES	NO
11. Have you EVER lost vision in either eye (temporarily or permanently)?	☐	☐
12. Do you CURRENTLY have any of the following vision problems?	YES	NO
a. Wear contact lenses	☐	☐
b. Wear glasses	☐	☐
c. Color blind	☐	☐
d. Any other eye or vision problems:	☐	☐
13. Have you EVER had an injury to your ears, including a broken ear drum?	☐	☐
14. Do you CURRENTLY have any of the following hearing problems?	YES	NO
a. Difficulty hearing	☐	☐
b. Wearing a hearing aid	☐	☐
c. Any other hearing or ear problems:	☐	☐
15. Have you EVER had a back injury?	☐	☐
16. Do you CURRENTLY have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet	☐	☐
b. Back pain	☐	☐
c. Difficulty fully moving your arms and legs	☐	☐
d. Pain or stiffness when you lean forward or backward at the waist	☐	☐
e. Difficulty fully moving your head up and down	☐	☐
f. Difficulty fully moving your head side to side	☐	☐
g. Difficulty bending at your knees	☐	☐
h. Difficulty squatting to the ground	☐	☐
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
j. Any other muscle or skeletal problems that interferes with using a respirator:	☐	☐

Part B. Medical Evaluation Questionnaire – Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire. (*HealthWorks providers request that all persons wearing a respirator answer these questions.)	YES	NO
1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amount of oxygen?	☐	☐
If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions?	☐	☐
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes, or dust) or have you come into skin contact with hazardous chemicals?	☐	☐
If yes, name the chemicals if you know them:		

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_____

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3. Have you ever worked with any of the materials, or under any of the conditions, listed below?	YES	NO
a. Asbestos	☐	☐
b. Silica (e.g. in the sandblasting)	☐	☐
c. Tungsten/cobalt (e.g. grinding or welding this material)	☐	☐
d. Beryllium	☐	☐
e. Aluminum	☐	☐
f. Coal (for example, mining)	☐	☐
g. Iron	☐	☐
h. Tin	☐	☐
i. Dusty environments	☐	☐
j. Any other hazardous exposures:	☐	☐
4. List any second jobs or side businesses you have:		
5. List your previous occupations:		
6. List your current and previous hobbies:		
7. Have you been in the military service?	☐	☐
If yes, were you exposed to biological or chemical agents (either in training or combat)?	☐	☐
8. Have you ever worked on a HAZMAT team?	☐	☐
9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over the counter medications)?	☐	☐
If yes, please name the medications if you know them:		
10. Will you be using any of the following items with your respirator(s)?	YES	NO
a. HEPA filters	☐	☐
b. Canisters (for example, gas masks)	☐	☐
c. Cartridges	☐	☐
11. How often are you expected to use the respirator(s)? (check yes or no for all that apply to you)	YES	NO
a. Escape only (no rescue)	☐	☐
b. Emergency rescue only	☐	☐
c. Less than 5 hours per week	☐	☐
d. Less than 2 hours per day	☐	☐
e. 2 to 4 hours per day	☐	☐
f. Over 4 hours per day	☐	☐
12. During the period you are using the respirator(s), is your work effort:	YES	NO
a. LIGHT – (less than woo kcal per hour): If yes, how long does this period last during the average shift: _____hrs _____min Examples of light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines	☐	☐
b. MODERATE – (200-350 kcal per hour): If yes, how long does this period last during the average shift: _____hrs _____min Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface	☐	☐
c. HEAVY – (above 350 kcal) If yes, how long does this period last during the average shift: _____hrs _____min Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling, standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)	☐	☐
13. Will you be wearing protective clothing and/or equipment (other than the respirator), when you're using your respirator? If yes, describe this protective clothing and/or equipment:	☐	☐
14. Will you be working under hot conditions (temperatures exceeding 77 degrees F)?	☐	☐
15. Will you be working under humid conditions?	☐	☐

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16. Describe the work you'll be doing while using your respirator:
_____
_____
___
_____
___

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):
_____
_____
___
_____
___

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s) (if unsure, please ask employer):

1. Name of the first toxic substance:_____
   a. Estimated maximum exposure level per shift:
      _____
   b. Duration of exposure per shift:
      _____

2. Name of the second toxic substance:
   _____
   a. Estimated maximum exposure level per shift:
      _____
   b. Duration of exposure per shift:
      _____

3. Name of the third toxic substance:
   _____
   a. Estimated maximum exposure level per shift:
      _____
   b. Duration of exposure per shift:
      _____

4. The name(s) of any other toxic substance that you'll be exposed to while using your respirator:
   _____
   _____
   __

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):
_____
_____
___
_____
___

Please explain all YES responses: Number:	**Explanation**

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_____
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I shall report to my employer any changes in my health condition that are related to my ability to use a respirator. I, the undersigned, hereby certify that the answers to the above questions are true to the best of my knowledge.

_____	_____
Employee's Signature	Date
_____	_____
Reviewer's Signature	Date

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_____

DOB: ___/___/___MR#:_____