LOYOLA MEDICINE

A Member of Trinity Health

MR: _____

Employee Health
Loyola Mulcahy Center - Suite 1600
2160 S 1st Ave
Maywood, Illinois 60153
708.216.3156

M 7:30AM to 7:30PM
T/W/TH 7:30AM to 4PM
F 7:30AM to 12PM
Bring your Immunization Records, if available, and Photo ID.

HEALTH HISTORY QUESTIONNAIRE

Name				**Gender:**
Address			**Age**	**Date of Birth**
City	**State**	**Zip**	**Last 4 digits Social Security #**	
Phone #	**Home:**	**Cell:**		**Work:**
Position / Occupation:				
Emergency Contact (relationship):				
Cell phone :				

VACCINATIONS: Please bring *official documentation* from your doctor for the following:

COVID-19 Vaccines:	_____ _____ Date Date
Measles, Mumps and Rubella (MMR) Vaccines:	_____ _____ Date Date
Varicella Vaccine:	_____ _____ Date Date
Measles, Mumps, Rubella and Varicella Titers:	Provide lab copies
Influenza Vaccine:	_____ Date
Hepatitis B Vaccine:	_____ _____ _____ Date Date Date
Hepatitis B antibody**:**	Provide lab copy
TDAP (Tetanus Diphtheria, Pertussis) :	_____ Date

Are you currently taking any medications that could or will interfere with your ability to perform the essential functions of your position? *Answer Yes or No.* If yes, please identify:

_____

Please continue on other side

MR: _____

Are you are allergic to or have bad reactions to any medicines? (Rx or over-the-counter) ***Answer Yes or No.***
If yes, please identify:

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Do you have any disability that could or will interfere with your ability to perform the essential functions of your position? *Answer Yes or No***. If yes, please identify:**

Do you require any accommodation(s) in order to perform your position? ***Answer Yes or No*****. If yes, please identify:**

You must provide medical documentation of required accommodations.

Applicant Signature: _____ **Date:** _____

Under Age 18 requires signature of Parent or Legal Guardian (circle one):

Signature: _____ **Date:** _____

To be completed by Employee/Student Health RN/APN
[] Physically qualified to perform essential functions of position without restrictions.
[] Physically qualified to perform essential functions of position with the following ADA accommodations _____
[] Not physically qualified to perform essential functions of position.
[] Unable to determine at this time. Further documentation requested regarding:_____

Signature: _____ **Date:** _____