LOYOLA MEDICINE

A Member of Trinity Health

MR: _____

Employee & Student Health Service
Loyola Outpatient Center / 3rd Floor Room 3201
2160 S 1st Ave
Maywood, IL 60153
Phone for Appointment: 1-888-584-7888
Hours:

M 7:30AM to 7:30PM
T/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:** _____