Title: **Baseline Comprehensive Health History**

BAXTER MEDICAL CONFIDENTIAL FORM

This information is being collected to assess candidate suitability for the role applied and to establish baseline health information to monitor employee health related to work at Baxter and is only used by occupational health professionals.
The information you provide is protected by the Baxter EHS Employee Health and Exposure Records Policy HCM-01-03 and in accordance with Baxter's Candidate Personal Information Collection Statement & Consent.

Please Print:

TO BE COMPLETED BY APPLICANT/EMPLOYEE

Date: _____

For Company Use

Position Applied For _____ _____

Division *Facility*

SURNAME:	**GIVEN NAME(S):**
Address: Street: _____ Suburb: _____ State: _____ Post code: _____	Phone number: Date of Birth:
IN CASE OF EMERGENCY, PLEASE NOTIFY: Name:_____ Relationship:_____ Phone no. (Work)_____ (Home):	Address: Street:_____ Suburb:_____ State: _____ Post code: _____
LOCAL DOCTOR: ☐ Name:_____ Phone No: ( ) ☐ I have no Family Doctor	Address: Street:_____ Suburb:_____ State: _____ Post code: _____

OCCUPATIONAL HISTORY:	Employer	Length of Service	Known Health Hazards
Present occupation:			
Previous occupation:			

ATTENTION: DOCTOR OR NURSE

A written job description detailing the physical demands of the position being filled should be included with this form. Be certain that the information elicited from applicants/employees is requested within the context of their ability to perform the essential functions of their job requirements

Title: **Baseline Comprehensive Health History**

Baseline Comprehensive Health History *(continued)*

Yes	No	
☐	☐	**Have you ever been hospitalized, had surgery or had a serious illness?**
☐	☐	**Are you allergic to any medications? If yes, list:**
☐	☐	**Are you allergic to dust or chemicals? If yes, list and describe:**
☐	☐	**Are you allergic to any products, foods, animals or animal products? If yes, list and describe:**
☐	☐	**Have you had / do you have any infectious diseases e.g. tuberculosis, HIV, Hepatitis? If yes list:**
☐	☐	**Have you had any problems with the use of personal protective-equipment? If yes, list:**

If your drinking, smoking or exercise may prevent you from, or inhibit you, in performing the duties identified for the role sought, please answer the following questions:

Yes	No	
☐	☐	Have you ever smoked cigarettes? If yes, at what age did you start? _____ For how many years? _____ How many packs per day (average): _____
☐	☐	Do you still smoke cigarettes? If no, age stopped: _____
☐	☐	Have you ever smoked a pipe or cigars on a regular basis? If yes, times per day? _____
☐	☐	Do you drink alcoholic beverages? If yes, amount per week? Liquor _____ beer _____ wine _____
☐	☐	Exercise? If yes: Frequency _____ Type _____ _____

List:

Recreational activities and hobbies: particularly those that may interfere with your employment availability:

_____
_____
_____

☐ Yes ☐ No Any restrictions, limitations or disabilities?

Females Only (answer only if role applied for is in Compounding Pharmacy or pharmaceutical manufacturing chain, due to potential chemical exposure risk)

☐ Yes ☐ No Do you still menstruate?

_____ Number of pregnancies?

_____ Number of stillbirths?

_____ Number of miscarriages?

Title: **Baseline Comprehensive Health History**

Baseline Comprehensive Health History *(continued)*

Review of Overall Health. Have you had or experienced:

Yes	No		Yes	No	
		Nervous System			**Throat and Neck**
☐	☐	Dizziness or light headedness	☐	☐	Sore throat problems swallowing
☐	☐	Loss of memory	☐	☐	Frequent stiff neck
☐	☐	Stroke	☐	☐	Neck pain or other neck trouble
☐	☐	Head injury / X-ray of skull	☐	☐	Thyroid problems
☐	☐	Loss of consciousness			**Lungs**
☐	☐	Numbness, tingling or weakness in a part of your body	☐	☐	Tightness in chest
☐	☐	Frequent or persistent headaches or migraines	☐	☐	Shortness of breath
☐	☐	Problems with coordination	☐	☐	Tuberculosis
☐	☐	Loss of strength in arms, hands or legs	☐	☐	Pneumonia/Bronchitis
☐	☐	Frequent tension, can't relax/panic attacks	☐	☐	Asthma
☐	☐	Mental health condition: depression / psychiatric problem	☐	☐	Emphysema
☐	☐	Seizures, convulsions	☐	☐	Any trouble/difficulty with breathing
☐	☐	Other nervous or neurological trouble			**Musculoskeletal**
		Eyes	☐	☐	Neck or shoulder pain
☐	☐	Seeing double or blurred vision	☐	☐	Pain in back
☐	☐	Cataracts or glaucoma	☐	☐	Painful joints, knees or shoulders
☐	☐	Do you have colour blindness	☐	☐	Broken bone(s) or torn cartilage
☐	☐	Eye allergies, itchy eyes	☐	☐	Arthritis or gout
☐	☐	Other eye trouble	☐	☐	Wrist pain or surgery
☐	☐	Do you wear glasses or contact lenses	☐	☐	Back or spine x-rays
		If wearing corrective lenses, date of last exam:	☐	☐	Back or spine surgery
		_____	☐	☐	Wrist / elbow pain or injury
		Nose, Ears and Hearing	☐	☐	Problem with hands/fingers
☐	☐	Difficulty in hearing	☐	☐	Tennis Elbow or Carpal Tunnel Syndrome
☐	☐	Ringing or buzzing in ears	☐	☐	Any other joint or bone trouble
☐	☐	More than one ear infection			_____
☐	☐	Other ear trouble			
☐	☐	Sinus trouble			
☐	☐	More than 3 colds or flu per year			

Title: **Baseline Comprehensive Health History**

Yes	No		Yes	No	
		Nose, Ears and Hearing (Continued)			**Heart**
☐	☐	Other ear trouble	☐	☐	Heart murmur
☐	☐	Sinus trouble	☐	☐	Swelling of ankles, feet or fingers
☐	☐	More than 3 colds or flu per year	☐	☐	Pain or pressure in chest
☐	☐	More than 3 nosebleeds per year	☐	☐	Thumping, skipping or racing heart/palpitations
☐	☐	Loss of sense of smell	☐	☐	Tire easily with exertion
☐	☐	Ear or nose surgery	☐	☐	High blood pressure
		Skin	☐	☐	Heart attack
☐	☐	Warts or moles that change in size or color	☐	☐	Heart surgery: Explain:
☐	☐	Skin cancer	☐	☐	Other heart trouble
☐	☐	Skin rashes such as Eczema, Psoriasis or Hives			
☐	☐	Frequent itching or wounds on the skin			

Review of Overall Health. Have you had or experienced:

Yes	No		Yes	No	
		Urinary System			**Digestive System (stomach)**
☐	☐	Kidney or bladder trouble such as infections, stones	☐	☐	Ulcer, heartburn or indigestion requiring treatment
☐	☐	Difficult or painful urination, or Dark urine	☐	☐	Gall bladder trouble
☐	☐	Kidney or bladder surgery	☐	☐	Frequent vomiting, nausea or diarrhea
		Other Illnesses	☐	☐	Frequent stomach pain
☐	☐	Diabetes	☐	☐	Blood in your stool
☐	☐	Cancer or Leukemia	☐	☐	Other digestive trouble
☐	☐	Anemia or other blood disease			**Immunisation History**
☐	☐	Malaria			Have you received the following:
☐	☐	Hepatitis (liver disease, yellow jaundice)	☐	☐	Tetanus: Last Date:_____
☐	☐	Birth defects or abnormality	☐	☐	Hepatitis B Series:_____
☐	☐	Phlebitis/varicose veins	☐	☐	Hepatitis A:_____
☐	☐	Weight loss for no reason	☐	☐	MMR:_____
☐	☐	Reduced appetite	☐	☐	TB Screening Method: _____
☐	☐	Lack of energy/fatigue			Test Results:_____
☐	☐	Frequent fever, chills or sweating			

Title: **Baseline Comprehensive Health History**

Exposure History

Have you ever worked with any of the following in previous jobs or outside activities (part-time or second jobs, hobby, gardening, farming etc)?

Yes	No		Yes	No	
☐	☐	Agricultural dust, mold or mildew	☐	☐	Laboratory animals
☐	☐	Anesthetic gases	☐	☐	Micro-organisms/Bacteria
☐	☐	Antibiotics	☐	☐	Noise
☐	☐	Asbestos	☐	☐	Radiation/Lasers
☐	☐	Blood or other body fluids	☐	☐	Silica or sand dust
☐	☐	Chemotherapy drugs	☐	☐	Solvents or dry cleaning agents
☐	☐	Coal dust	☐	☐	Uranium
☐	☐	Cotton dust	☐	☐	Drug mfg. or compounding: _____
☐	☐	Ethylene oxide			_____
☐	☐	Fungicides, insecticides, herbicides	☐	☐	**Other:**
☐	☐	Heavy metals (Cadmium, Cobalt, Lead, Mercury)			_____

I certify that all the information submitted by me on this application is true and accurate. I understand that if any false information, misrepresentation of facts, or omissions are discovered, my application may be rejected and, if I am employed, my employment may be terminated.

Employee Signature: _____ **Date:** _____

Note to physician or nurse: Please expand or clarify answers as necessary. _____

_____

Reviewed by: _____ _____

Baxter or Representative Health-care Provider Signature Date: