

**STRONG HEALTH
HIGHLAND HOSPITAL**

Volunteer Health Requirements

NAME _____ D.O.B. ____/____/____ AGE ____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

TELEPHONE NUMBER ____ - ____ - ____ S.S.# _____

DEPARTMENT/JOB _____

Active Medical Problems

Medications (including non-prescription)

Allergies

Environmental _____

Medication _____

Latex _____

Hospitalization or Surgery

Date Reason

SYSTEMS REVIEW

Please check all that apply:

<input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Ear Infection—frequent <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Failing Vision <input type="checkbox"/> Eye Infection <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Sore Throats-- <i>frequent</i> <input type="checkbox"/> Hayfever/allergies <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis/Chronic Cough <input type="checkbox"/> History of TB <input type="checkbox"/> Positive TB Skin Test <input type="checkbox"/> Asthma/Wheezing <input type="checkbox"/> Chest pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Leg pain--walking <input type="checkbox"/> Varicose veins/Phlebitis <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Indigestion or heartburn <input type="checkbox"/> Persistent Nausea/Vomiting <input type="checkbox"/> Peptic ulcer <input type="checkbox"/> Abdominal pain-- <i>chronic</i>	<input type="checkbox"/> Gallbladder <input type="checkbox"/> Jaundice/Hepatitis <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's/Colitis <input type="checkbox"/> Blood or Tarry Stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Urine Infections--frequent <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urination <input type="checkbox"/> Overnight > Twice <input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control <input type="checkbox"/> Decrease in flow <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Urethral Disease <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Weight loss—recent <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Convulsions/Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor/Hands shaking <input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Arthritis/Rheumatism <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Back pain/Sciatica <input type="checkbox"/> Bone fracture/joint injury <input type="checkbox"/> Knee problems <input type="checkbox"/> Bursitis/Tendinitis <input type="checkbox"/> Muscle or tendon damage <input type="checkbox"/> Foot pain <input type="checkbox"/> Cold numb feet <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Memory Loss <input type="checkbox"/> Moodiness—Excessive <input type="checkbox"/> Phobias <input type="checkbox"/> Mental Illness <input type="checkbox"/> Lactose intolerance <input type="checkbox"/> Prostate disease <input type="checkbox"/> Sexual/Menstrual dysfunction <input type="checkbox"/> Frequent infections Females: Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
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Have you ever been treated for, or received benefits for an accident or disease connected with Worker's Compensation or Disability Benefits? Yes No

If yes, state the nature of injury and give details below.

Highland Hospital Immunization Permission Form

Name of Volunteer: (please print) _____

I, the undersigned, an applicant for volunteering at the Highland Hospital, Rochester, NY do hereby certify that I have reviewed the foregoing information supplied by me and state that it is true and complete to the best of my knowledge.

Date: _____

Signed: _____

I hereby grant permission to Highland Hospital Employee Health Service to administer PPD, Rubella Titre, and Rubeola Titre tests.

Date: _____

Signed: _____