Dartmouth-Hitchcock Medical Center
Occupational Medicine
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Dartmouth-Hitchcock

TRANSFER/UPDATE FORM FOR DHMC EMPLOYEES

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____

Type of Work/Employment: _____ Effective Date: _____

Current/Previous Position & Department: _____

New Position and Department: _____
New Supervisor: _____

Since your last evaluation or pre-employment screening in Occupational Medicine:

1. Have you had any new medical problems, seen your healthcare provider for illnesses or allergies, had any surgeries/procedures, or sustained any work related injuries? (If yes, please include the date.) _____
_____
_____
_____

2. Are you currently working in a modified capacity or with accommodations? If so, is this considered a Temporary or Permanent accommodation? ____Temporary _____ Permanent Please explain:
_____
_____

Do you have a Primary Care Provider? Yes ☐ No ☐
If yes, please provide name of provider and practice location _____

MEDICAL HISTORY
Some work assignments may be associated with chemical, biological, electrical, or physical hazards. For example, some jobs may require the ability to lift and carry heavy objects, to stand or walk on uneven surfaces, to climb on ladders or scaffolding, to perform prolonged bending of the neck and back, or to perform repetitive movements of the neck or extremities. Some work assignments could be extremely dangerous in the event of dizziness, loss of consciousness, or loss of balance. Considering this, indicate if you have or have ever had any of the following conditions. Please describe in the space provided.

☐Heart disease
☐High blood pressure
☐Circulation or bleeding condition
☐Stroke
☐Asthma or breathing condition
☐Hepatitis or liver condition
☐Kidney condition
☐Cancer
☐Hernia
☐Chronic infection
☐Prosthesis
☐Diabetes
☐Low blood sugar
☐Seizures or epilepsy
☐Nervous system condition
☐History of fainting or losing consciousness
☐Problems with balance
☐Immune disorder or suppression
☐Vision or hearing problem
☐A sleep disorder or problems sleeping that interferes with your alertness at work?
☐History of anaphylaxis or throat swelling

☐Gastrointestinal condition
☐Sensitivity to chemicals or soaps
☐Eczema, dermatitis, hives, or other skin condition
☐Environmental, pet, seasonal, drug, or product allergies
☐Are you currently or have you ever used tobacco or nicotine products?
Amount per day: _____
☐Other: _____
For any checked boxes, please explain:
_____
_____
_____

Do you have any of the following **orthopedic problems** (including any muscle, joint, bone, or nerve condition) that affects your strength, grip, motion, or ability to sit, stand, walk, squat, kneel, bend, climb, lift, carry, push or pull heavy objects, or work on slippery or uneven surfaces, or work in a stooped or squatting position).
☐Back injury or problem:
☐Neck injury or problem:
☐Shoulder, elbow, or arm injury or problem:
☐Hand or wrist injury or problem:
☐Hip, knee, or leg injury or problem:
☐Foot or ankle injury or problem:

MEDICATIONS
Please list all medicines you currently use with dose and frequency. Include non-prescription, over-the-counter medicines (aspirin, vitamins, etc).

_____ _____
_____ _____
_____ _____

☐I permit the section of Occupational Medicine to have access to my complete Dartmouth Hitchcock medical record for the purposes of immunization review and update.

I understand this form is part of my confidential occupational medicine medical record and will not be released without my written permission.

Employee Signature: _____ Date: _____

Upon review of this form, Occupational Medicine may contact you regarding any questions or to make arrangements to comply with any infectious disease/OSHA compliance policies.

OHN NOTES:
_____
_____
_____

Reviewed by OccMed Nurse: _____ Date: _____

☐Clearance Form sent to new Supervisor Date:_____ RN Initials:_____