Sinai Health

CLEAR

HEALTH REVIEW QUESTIONNAIRE

The purpose of the Health Review Questionnaire is to gather information that will help the Occupational Health team determine if there are any safety considerations or accommodations required for employees. This form must be completed by employees, scientists, researchers on hospital payroll, and volunteers.

Completed forms should be sent by email or fax to Occupational Health and Safety at the campus you were recruited by:

- Mount Sinai Hospital campus: oshmsh@sinaihealth.ca or 416-361-2663 (fax)
- Hennick Bridgepoint Hospital campus: ohs.hbh@sinaihealth.ca or 416-470-6725 (fax)

SECTION A - IDENTIFICATION

LAST NAME:	**FIRST NAME:**
ADDRESS:	**TELEPHONE:** **EMAIL:**
JOB TITLE:	**DEPARTMENT:**
PRIMARY CAMPUS: ◯ Mount Sinai Hospital ◯ Hennick Bridgepoint Hospital ◯ Other:	**MANAGER:** **START DATE:**

SECTION B - PERSONAL MEDICAL HISTORY

The following questions are important to identify any health conditions that could be affected by potential exposure to workplace hazards.

1. Have you ever received medical treatment for the following? Please check all that apply.

☐ Back/neck injury or pain	☐ Seizures/loss of consciousness
☐ Upper extremity (shoulder, elbow, wrist, or hand) injury or pain	☐ Respiratory problems
☐ Lower extremity (hip, knee, lower leg, ankle, or foot) injury or pain	☐ Immunosuppression
☐ Visual impairment	☐ Hepatitis
☐ Hearing impairment	☐ HIV
☐ Neurological conditions	☐ Skin sensitivity or latex allergy
☐ Any other relevant medical conditions you want to disclose related to your safety or accommodation needs (please describe):	

2. **Have you ever had a work-related injury or illness?** Yes ☐ No ☐ If yes, please describe:

3. **Do you have restrictions that require accommodation related to your personal safety in the event of an emergency evacuation?** Yes ☐ No ☐ If yes, please describe:

4. **Do you have any skin conditions on your hands (symptoms like redness, open areas, cracks, dryness, itchy, burning, soreness) that may impact your ability to follow proper hand hygiene requirements?** Yes ☐ No ☐ If yes, please describe:

5. **Do you require accommodation to complete your essential job duties now?** Yes ☐ No ☐
If yes, please describe:

C. AUTHORIZATION

I hereby declare that this information is true and complete. I understand that all medical information provided by me will be kept confidential as per the Sinai Health Confidentiality of Employee Information Policy.

EMPLOYEE SIGNATURE:_____ **DATE:**_____

Sinai Health is committed to protecting your privacy. The personal information collected in this form is collected in accordance with the Occupational Health and Safety Act and the Workplace Safety and Insurance Act. It will be used and maintained by the institution for the intended purpose of providing you with Occupational Health and Safety services. If you have any questions about the collection, use and disclosure of the information provided on this form, please contact the OHS Department using the contact information above.