Pacific Endoscopy Center

Covenant Physician Partners
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EMPLOYEE HEALTH SCREENING
(*NEGATIVE* TB SKIN TEST FORM)

☑ TB Skin Test & TB Questionnaire Review ☑ Annual Health Review ☐ Exposure

Print Full Legal Name:	Date of Birth:	Title/Position:	Phones
Vincent Fredrick Icaza	4/16/87	CRNA	Cel: 708-466-6256 Work: (808) 456-6420

TB QUESTIONNAIRE:		
1. Have you ever had a positive (reactive) skin test? If NO, see TB Skin Test info section below	☐ Yes	☑ No
2. Have you ever received INH (Isoniazid), a medication given for a positive skin test?	☐ Yes	☑ No
3. Have you ever received a BCG, a childhood TB vaccine used in foreign countries?	☐ Yes	☑ No
4. In the past 6 weeks have you taken cortisone/steroid pills or injections?	☐ Yes	☑ No
5. Have you had a live vaccine (i.e. measles or chickenpox) in the past 2 months?	☐ Yes	☑ No
6. Are you currently experiencing: a. cough lasting longer than 3 weeks?*	☐ Yes	☑ No
If you develop any of these symptoms (6a-6f), notify Center Manager and contact Primary Care Physician as soon as possible. b. fever?*	☐ Yes	☑ No
c. night sweats (unrelated to weather or menopause)?*	☐ Yes	☑ No
d. coughing/spitting blood?*	☐ Yes	☑ No
e. unexplained fatigue?*	☐ Yes	☑ No
f. unexplained weight loss of more than 10lbs in last 2 months?*	☐ Yes	☑ No
Explain all YES answers here:		
7. Any infectious or communicable disease since your last exam? Please explain. (i.e. herpes, chickenpox, conjunctivitis, skin infection, diarrhea) _____	☐ Yes	☑ No
8. Any chronic disease (i.e. diabetes, chronic infections, kidney problems or any disease) that affects your immune system? Please list.	☐ Yes	☑ No
FOR ANNUAL HEALTH REVIEW:		
9. Have you had any illness or physical disability that impairs, or oculd impair your ability to perform your job responsibilities? If yes, explain. _____	☐ Yes	☑ No

I acknowledge that I have read the above and that all my responses are true and accurate. It is my responsibility to notify the Center and my physician of my skin test positive status and request radiological testing as well as physical exam at any time I have respiratory symptoms including but not limited to the above. (Please retain a copy for your records for at least a year.)

Employee Signature _____ Date 8/23/23

I have reviewed the above information supplied by this employee. General physical appearance : ☑ *WNL.* ☐ *Other: (Pls explain)* _____

Licensed Medical Staff Signature _____ Date AUG 23 2023

TB SKIN TEST RECORD
(THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER)

Date Given: 8/23/23	Site: L ✓ R ___ Forearm Lot No: 2CA9227 Exp. Date 9/2026	Name of Facility: Pacific Endoscopy By (print name): Brenda Morelhao Signature: [signature]
Date Read: 8/25/2023	☑ Negative ☐ Positive Induration: 0 mm Erythema: 0 mm	Name of Facility: PEC By (print name): D Jun Obaldo Signature: [signature]

Chest X-ray: Results: _____ Date: _____	Date Referred To: DOH: _____ PMD: _____	Clearance Card: Date Received: _____ By: _____	Foreign travel in past 2 yrs? ☐ Yes ☐ No Close contact with active TB? ☐ Yes ☐ No