BASELINE HEALTH HISTORY SCREENING QUESTIONNAIRE

Last Name:		**First Name:**			
Date: ____/____/____ MM DD YYYY	**SSN:** _____-_____-_____	**DOB:** ____/____/____ MM DD YYYY	**Age:**		
Location:		**Position Offered:**			
Home Address:		**City:**		**State:**	
Home Phone:		**Cell Phone:**			

Dear Prospective Employee:

This screening questionnaire is to be completed by a prospective employee after a conditional offer of employment is made. This is a confidential document and will be treated as such at all times. The completed questionnaire will be reviewed by our Medical Support Specialist and will be maintained in a confidential medical file. Our Medical Support Specialist may refer you to our Occupational Health Clinic for an evaluation by our Occupational Health Care Professional based your responses. The overall purpose of this screening questionnaire and evaluation (if required) is to evaluate your ability to perform the essential functions of the job that has been offered with or without a reasonable accommodation.

Please review the job description that is included in your new hire information packet prior to completing the Baseline Health History Screening Questionnaire. When completed, verify that you have signed and dated the questionnaire before returning it to your hiring manager or another member of management in a sealed envelope within **24 hours** of receipt.

YES	NO	QUESTION
		SECTION I
		1.0 Infectious Disease and/or Illness/Adverse Health Conditions/Implantable Devices
		A. Do you currently have any condition(s) that could adversely affect the safety of others or BioLife Plasma Services products (i.e., Plasma) such as:
☐	☐	1. Unexplained fever lasting more than 3 days?
☐	☐	2. Flu like symptoms lasting more than 2 weeks?
☐	☐	3. Productive cough lasting more than 10 days?
☐	☐	4. Eye infection and/or eye drainage?
☐	☐	5. Jaundice (yellow eyes/skin)?
☐	☐	6. Generalized rash?
		B. Skin lesions that are:
☐	☐	1. Small and blister like?
☐	☐	2. Weeping?
☐	☐	3. Pustular?
☐	☐	4. Flaking?
		C. Implantable Devices:
☐	☐	1. Do you have a pacemaker or other implantable device or are you currently a candidate to receive one?
☐	☐	2. Are you aware of any limitations to work with devices that emit low level electromagnetic frequency?
		2.0 Chemical and Environmental Sensitivities
☐	☐	A. Do you have asthma or hay fever?
☐	☐	B. Have you ever experienced an allergic reaction (such as asthma, skin rash, hives) when exposed to chemical or environmental substances? ***if yes check which ones***: ☐ Soaps ☐ Hand Sanitizer ☐ N-butyl Alcohol ☐ Gloves (Latex, Nitrile, Vinyl) ☐ Iodine ☐ Isopropyl Alcohol ☐ Glycerin ☐ Ammonia Containing Products ☐ Other cleaners/disinfectants, please specify: _____
☐	☐	C. Have you ever experienced a problem while working in temperatures at or below Zero degrees Fahrenheit (0 F) or have been told that you have a medical condition that may affect your ability to work in cold temperatures?
☐	☐	D. Have you ever worked in cold temperatures (at or below Zero F) and developed a rash, frostbite or had difficulty working or concentrating?
☐	☐	E. Are you taking medication(s) that may affect your ability to work in cold temperatures (check with your personal physician if uncertain)?
		3.0 Latex Sensitivity - Latex containing products used in the center may include but are not limited to: a. Latex Gloves d. Donor Wrap b. Blood Pressure Cuffs e. Rubber Bands c. Stethoscopes f. Syringes
☐	☐	A. Have you suspected you had, have, or been told you had a reaction in which you experienced irritation, swelling and/or difficulty breathing following contact with latex substances? (Examples: balloons, elastic bands, condoms, diaphragms, gloves)

B. When exposed to latex or rubber, do you:

☐	☐	1. Suffer runny nose/eyes?
☐	☐	2. Experience wheezing or shortness of breath?
☐	☐	3. Do your hands "break out" within seconds to less than one hour of wearing latex/rubber gloves?
☐	☐	4. Do you have rash, itching, cracking, chapping, scaling, or weeping of the skin from latex glove use?
☐	☐	5. Do your lips swell or tingle when you blow up balloons?
☐	☐	6. Do you have a history of eczema, itching, rough skin, chapping, cracking or other rashes on your hands from rubber glove use?
☐	☐	7. Do you have a history of, or told you have a history of, anaphylaxis or intraoperative shock?

4.0 Hearing and Depth Perception

☐	☐	A. Have you ever experienced a problem with depth perception or have been told that you have a depth perception problem? *Note: Depth perception allows you to accurately gauge the distance to an object.*
☐	☐	B. Have you ever experienced a hearing loss, have problems hearing, or have been told that you have a hearing loss or problem?

5.0 Musculoskeletal Health

A. Please check any of the following if you are currently or within the last 3 years have experienced pain/discomfort 3 or more times per week *and/or* have ever been under a doctor's care for or sought medical treatment for problems associated with any of the below within the past 3 years?:

☐ head ☐ neck ☐ upper back ☐ mid back ☐ low back ☐ chest ☐ shoulder(s)
☐ arm(s) ☐ elbow(s) ☐ hand(s) ☐ finger(s) ☐ hip(s) ☐ leg(s) ☐ knee(s)
☐ feet(s) ☐ toe(s)

6.0 Lifting

☐	☐	A. Are you able to frequently lift an individual object weighing up to thirty-five (35) pounds and occasionally lift up to and including fifty (50) pounds?

7.0 Essential Functions of the Position

☐	☐	A. Can you perform the essential functions of the position you have been offered as described in the physical demands section of the job description?

SECTION II

1.0 General Health

☐	☐	A. Do you have any other known allergies/dermatitis?
☐	☐	B. Are you allergic to any medications?

Note: You will be offered the Hepatitis B vaccination series within 10 days after initial assignment as it applies to the position offered. You will be required to complete an Informed Consent Form accepting or declining the vaccination series. If you decline due to the fact that you have already been immunized, you will be required to obtain medical documentation from the provider of the vaccine (i.e.: previous employer).

I certify that all the information submitted by me on this questionnaire 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.

Print Name: _____ Date: _____/_____/_____
MM DD YYYY

Signature: _____

MEDICAL SUPPORT SPECIALIST'S RECOMMENDATION

I have assessed the responses provided to me on the Baseline Health History Questionnaire and recommend that the prospective employee

_____

(name of individual)

Is capable of performing the essential functions of the position offered with no restrictions. ☐**Yes** ☐**No**

Refer to the Occupational Health Clinic for a medical evaluation based on the responses and/or opinion of this Health Care Professional. ☐**Yes** ☐**No**

Reason(s):_____

_____

_____

_____

_____

_____

OR

Further actions are on hold until a consultation with the EHS Department in order to clarify company policy or practices, and/or additional concerns are addressed prior to sending the prospective employee to the Occupational Health Clinic for evaluation. ☐**Yes** ☐**No**

Further actions are on hold until a consultation with the HR and/or EHS Departments is conducted in order to determine if BioLife is able to accommodate the work restrictions placed on the prospective new hire by the Occupational Health Clinic ☐**Yes** ☐**No**

Medical Support Specialist (print): _____ Date:___/___/___

Signature of
Medical Support Specialist: _____

Document Approvals

Approved Date: 10 Jan 2022

Mandatory Owner Approval Verdict: Approve	Vee Bouikidis (tvz5796@shire.com) Document Owner Approval 09-Jan-2022 17:33:37 GMT+0000

Approval Task Verdict: Approve	Vee Bouikidis (tvz5796@shire.com) Owner Approval 09-Jan-2022 17:34:42 GMT+0000

Approval Task Verdict: Approve	Garrett Mohr (mohrg1@shire.com) Quality Approval 10-Jan-2022 13:46:50 GMT+0000