

SFVAHCS Baseline Health Status Intake Form

**Name** (Last): \_\_\_\_\_ (First): \_\_\_\_\_

**Social Security Number:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Preferred phone contact:** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**Birthdate** (month/day/yr): \_\_\_\_/\_\_\_\_/\_\_\_\_ **Preferred email:** \_\_\_\_\_

**Status:**  VA salaried employee  NCIRE (research)  UCSF or WOC  Volunteer  Other: \_\_\_\_\_

**Complete form and provide copies of ALL relevant vaccination/immunization/immunity documents**

<p align="center"><b>Measles/Mumps/Rubella (MMR)</b></p> <p>MMR Vaccination: <u>Or</u> Positive MMR Antibody (Immunity) Blood Test Dates: _____</p> <p>2 Shot Dates: Measles: ____/____/____ Mumps: ____/____/____ Rubella: ____/____/____</p> <p>1. ____/____/____ 2. ____/____/____</p>		<p align="center"><b>Varicella (Chicken Pox)</b></p> <p>Varicella Vaccination <u>Or</u> 2 Shot Dates: _____</p> <p>1. ____/____/____ 2. ____/____/____</p> <p>Zoster (Shingles) Vaccination 1 Shot Date : ____/____/____ 1. ____/____/____</p> <p>Varicella Antibody (Immunity) Blood Test Date: ____/____/____</p>	
<p align="center"><b>Hepatitis B (HBV)</b></p> <p>HBV Vaccination 3 Shot Dates : _____</p> <p>1. ____/____/____ 2. ____/____/____ 3. ____/____/____</p> <p>HBV Surface Antibody (Immunity) Blood Test Date: ____/____/____</p>		<p align="center"><b>Tetanus, Diphtheria and Acellular Pertussis (Tdap)</b></p> <p>Date of most recent tetanus shot: ____/____/____</p> <p align="center"><b>Influenza (Flu) Vaccination</b></p> <p>Date of most recent flu shot: ____/____/____</p>	
<p><b>Tuberculosis (TB) testing</b> by tuberculin skin test (PPD/TST) or by blood test (IGRA:- T-Spot or QuantiFERON)</p> <p><b>Most recent test performed :</b></p> <p>Skin test    Date ____ / ____ / ____    If known, mm reaction size : ____ ____    Positive    Negative</p> <p>Blood test    Date ____ / ____ / ____    Positive    Negative</p> <p>If skin or blood test positive:</p> <p>Chest X-ray done after positive test    Yes    No <b>[Attach report]</b></p> <p>Medication because of positive test    Yes    No</p> <p>Prior active TB disease    Yes    No</p> <p>Comments: _____</p>			
<p><b>My position will involve research</b>    Yes    No    <b>My position will include</b> (check below all that apply):</p> <p><input type="checkbox"/> Direct patient contact    <input type="checkbox"/> Possible direct contact with human blood, serum, fluids, cells</p> <p><input type="checkbox"/> Work with sheep    <input type="checkbox"/> Work with Hepatitis B virus (HBV) or HBV containing material</p> <p><input type="checkbox"/> Work with other animals    <input type="checkbox"/> Lab work with meningococcal bacterial specimens</p>			