Union Pacific Health and Medical Services

HEALTH HISTORY: RETURN TO WORK, GREATER THAN 1 YEAR

*Please complete this form and email to **FFDHHQ@up.com***

EMPLOYEE INFORMATION

Employee Name:	Employee ID:
Email Address:	Phone Number:

It is Union Pacific's policy that all employees be medically fit to perform their required job duties. The following attestations are intended to assist Union Pacific Health and Medical Services to make decisions regarding an employee's fitness for duty to return to work.

MEDICAL INFORMATION

Since you last worked at Union Pacific, have you been diagnosed or experienced any of the following:

Dizziness, loss of consciousness, tremors, altered consciousness, blackouts, syncope, or fainting	☐ YES	☐ NO
Heart problems, irregular heartbeats, skipped beats, palpitations	☐ YES	☐ NO
Angina, heart attack, congestive heart failure, enlarged heart, aortic aneurysms, or heart murmurs; peripheral vascular disease or vascular disease of any type	☐ YES	☐ NO
High blood pressure requiring more than 2 medications to control	☐ YES	☐ NO
Chest tightness, chest pain / pressure, shortness of breath	☐ YES	☐ NO
Diabetes, high blood sugar, or low blood sugar	☐ YES	☐ NO
Cancer or blood/immune disorders, blood clots or pulmonary embolus	☐ YES	☐ NO
Lung conditions such as emphysema, pneumonia, recurrent bronchitis, asthma, or other lung diseases; breathing problems or wheezing	☐ YES	☐ NO
Ear disorders, change in or loss of hearing or balance, dizziness or vertigo, hearing impairment	☐ YES	☐ NO
Tuberculosis or Valley Fever	☐ YES	☐ NO
Skin rashes, psoriasis, or eczema, other skin sensitivity, burns, diabetic ulcers or other skin breakdown	☐ YES	☐ NO
Head / Brain injuries, disorders, or illnesses, migraines / significant headaches, strokes, transient ischemic attacks (TIA)	☐ YES	☐ NO
Seizures, fits, or epilepsy	☐ YES	☐ NO
Eye disorders or impaired vision (except corrective lenses); eye surgery	☐ YES	☐ NO
Color vision problems	☐ YES	☐ NO
Heart or vascular surgery (valve replacement, any type of arterial bypass, angioplasty, pacemaker / defibrillator etc.)	☐ YES	☐ NO
Kidney disease, dialysis, kidney stones	☐ YES	☐ NO
Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring, evaluation for sleep apnea (or sleep study recommended)	☐ YES	☐ NO
Spinal injury or disease, including back and neck	☐ YES	☐ NO
Joint or bone injury or disease; broken bones; surgery on a bone or joint	☐ YES	☐ NO

Muscular disease/hernias/chronic low back pain	☐ YES	☐ NO
Injury, pain, or impaired use of hand, wrist, forearm, arm shoulder, foot/ankle, leg, knee, thigh or hip	☐ YES	☐ NO
Anxiety, depression, or other mental health conditions that interfere with function/concentration/interpersonal relationships or sleep; overwhelming stress; mood/bipolar disorder; phobias, or fears	☐ YES	☐ NO
Liver problems, hepatitis, cirrhosis, or pancreas problems	☐ YES	☐ NO
Weakness or chronic fatigue	☐ YES	☐ NO
Connective tissue disorder such as Lupus, Sarcoidosis, Rheumatoid Arthritis, or Sjogren's Syndrome	☐ YES	☐ NO
Recurrent, persistent cough requiring you to see a healthcare provider	☐ YES	☐ NO
Throat or voice problems	☐ YES	☐ NO
Digestive / gastrointestinal or stomach problems, difficulties swallowing	☐ YES	☐ NO
Neurological disorders, difficulties with tremor, paralysis, balance, coordination, speech, memory, or use of limbs; Parkinson's/Multiple Sclerosis/other chronic neurologic conditions	☐ YES	☐ NO
Endocrine disorders such as thyroid disease	☐ YES	☐ NO
Diabetes or elevated blood sugar,	☐ YES	☐ NO
If "YES" controlled by:	☐ Diet ☐ Insulin	☐ Pills ☐ Other
Difficulties standing, walking, climbing, using stairs	☐ YES	☐ NO
Issues with alcohol or substance use/abuse, abuse of prescription medications (including any therapy, treatment or rehabilitation)	☐ YES	☐ NO
Been hospitalized 24 hours or longer/ ER visit(s)	☐ YES	☐ NO
Had surgery on any body part or are taking medications for conditions/issues not on this questionnaire:	☐ YES	☐ NO
Had a chest X-ray while off work?	☐ YES	☐ NO

Please explain the above conditions:

Please list all medication, including dose and frequency of use:

Please list all surgeries:	
COVID-19: In that last 14 days, have you been in contact with someone who has tested positive or was presumed positive for COVID-19 or instructed to quarantine by a healthcare provider or a public health department for COVID-19?	☐ YES ☐ NO
COVID-19: In the last 72 hours, have you experienced any cold of flu-like symptoms (including, but not limited to, fever, cough, sore throat, respiratory illness, difficulty beathing, sudden loss of taste or smell) or traveled outside the stats except for work or communication to/from work AND have been experiencing flu-like symptoms?	☐ YES ☐ NO

I have read and understand the above questions and statements related to my medical history. I attest my responses are true and correct and I understand that if I provide false or incomplete information that I may be subject to discipline up to and including termination. If I have completed this form electronically, I agree that my electronic signature is the equivalent of my handwritten signature on this document.

Employee Name:

Employee Signature: Date:

Additional space for comments, if needed:

Please complete this form and email to FFDHHQ@up.com