

USPS NPM Health Assessment Form

A form needs to be completed for every person in the household. An adult should complete a separate sheet for each child age 17 or younger in your household. Each adult (age 18 and older) in the household needs to complete a separate form.

Name (Last, First): _____ Phone: _____ Address: _____ City: _____ State: _____ ZIP: _____ Date completed: _____	USPS Employee: ___ Yes ___ No Employee ID Number: _____ If No, name of USPS employee in your house: _____ _____																														
Health Care Provider Name: _____ Clinic: _____ City: _____ Phone: _____																															
Weight: _____ pounds Age: _____ years Can you swallow a pill? Yes No																															
Do you have any of the following health conditions: a. Advanced kidney disease or serious decrease in kidney function? b. Advanced liver disease, such as cirrhosis? c. Currently pregnant or breastfeeding?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> </tr> <tr> <td> a.</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td> b.</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td> c.</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> </table>		Yes	No	a.	Yes	No	b.	Yes	No	c.	Yes	No																		
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Are you currently taking any prescription drugs?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> </tr> <tr> <td>Yes</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> </table>		Yes	No	Yes	Yes	No																								
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If "Yes," do any of them include: (mark all medications) Oral contraceptives (i.e., birth control pills) _____ Warfarin (Coumadin) _____ Digoxin (Lanoxin and others) _____ Phenytoin (Dilantin) _____ Isoretinoin (Accutane) or Acitretin (Soriatane) _____ Phenobarbital _____ Lithium _____ Methotrexate _____ Carbamazepine (Tegretol) _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 25%; text-align: center;">Yes</td> <td style="width: 25%; text-align: center;">No</td> </tr> <tr> <td>Oral contraceptives (i.e., birth control pills)</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Warfarin (Coumadin)</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Digoxin (Lanoxin and others)</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Phenytoin (Dilantin)</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Isoretinoin (Accutane) or Acitretin (Soriatane)</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Phenobarbital</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Lithium</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Methotrexate</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Carbamazepine (Tegretol)</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> </table>		Yes	No	Oral contraceptives (i.e., birth control pills)	Yes	No	Warfarin (Coumadin)	Yes	No	Digoxin (Lanoxin and others)	Yes	No	Phenytoin (Dilantin)	Yes	No	Isoretinoin (Accutane) or Acitretin (Soriatane)	Yes	No	Phenobarbital	Yes	No	Lithium	Yes	No	Methotrexate	Yes	No	Carbamazepine (Tegretol)	Yes	No
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Have you ever had an allergic reaction to any doxycycline or another tetracycline drug (see Partial List of Tetracycline Drugs at the bottom of this page) Yes No																															
<p>An allergic reaction (anaphylaxis) usually includes one or more of the following symptoms: skin rash, hives, or itching; wheezing, shortness of breath, or trouble breathing; swelling of the face, lips, or throat; and allergic shock. Allergic reactions usually DO NOT include symptoms like mild nausea or vomiting, upset stomach, loose stools (including diarrhea) vaginal yeast infection, or headache.</p> <p style="text-align: center;">Partial List of Tetracycline Drugs:</p> Chlortetracycline (Aureomycin) Demeclocycline (Declomycin) Doxycycline (Adoxa, Atridox, Bio-Tab, Doryx, Doxychel, Doxy, Monodox, Periostat, Vibra-Tabs, Vibramycin) Minocycline (Arestin, Dynacin, Minocin, Vectrin) Oxytetracycline (Terak, Terra-Cortril, Terramycin, Urobiotic-250) Tetracycline (Achromycin V, Bistracycline, Sumycin, Tetrex, Topicycline, Helidac)																															

Staff Use Only

Drug Dosage	Initial and Date	Affix label or Write Rx#, Lot #, and Expiration Date
USPS Employee: Provide: Doxycycline 100 mg tablets (1 bottle of 20 tablets for storage at HOME)		
USPS Employee: Provide: Doxycycline 100 mg tablets (1 bottle of 20 tablets for storage at WORK)		
Household Member: Provide: Doxycycline 100 mg tablets (1 bottle of 20 tablets for storage at HOME)		
NDMS Health Care Professional Name (printed): _____ Signature: _____ Daytime Phone: _____ Date Reviewed: _____		
Contact with USPS Employee: Date of Contact: _____ Approved: Yes No		