

Pre-Employment Physical Assessment Annual Assessment Return to work/LOA Other:

Name: _____ Marital Status: M S W D Sex: M F

DOB: _____ SS #: _____ Title: _____

PHYSICAL EXAMINATION

HEAD/ENT:					
EYES:					
NECK:					
BREASTS:					
LUNGS:					
CARDIOVASCULAR:					
MUSCULOSKELETAL:					
ABDOMEN:					
GENITOURINARY:					
CENTRAL NERVOUS SYSTEM:					
COMMENTS:					
HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS (Copy of Lab report with values required)

TEST	DATE PERFORMED	RESULTS PROVIDE LAB VALUES AND INTERPRETATION
RUBELLA TITER		<input checked="" type="checkbox"/> NON-IMMUNE <input type="checkbox"/> IMMUNE LAB VALUE:
MEASLES TITER		<input checked="" type="checkbox"/> NON-IMMUNE <input type="checkbox"/> IMMUNE LAB VALUE:
DRUG SCREEN		<input checked="" type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE SUBSTANCE:

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
INFLUENZA VACCINE	1.		
COVID VACCINE (TYPE)	1.	2.	

- This individual is free from any health impairment that is a potential risk to the patient or other employee or which may interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol.
- This individual is able to work with the following limitations:
- This individual is not physically/mentally able to work. (*specify reason*):

Physician Signature: _____ Lic. No. _____

Date: _____

Pre-Employment Assessment Other:

NAME: _____ TITLE: _____

INTERFERON GAMMA RELEASE ASSAY TESTING (Lab Attached)

DATE	RESULTS	INTERPRETATION	COMMENTS

MANTOUX/PPD (5UPPD)

DATE IMPLANTED	IMPLANTED BY:	DATE READ	READ BY	INTERPRETATION IN MILLIMETERS
MANUFACTURER:		LOT NUMBER:		

MANTOUX/PPD (5UPPD)

DATE IMPLANTED	IMPLANTED BY:	DATE READ	READ BY	INTERPRETATION IN MILLIMETERS
MANUFACTURER:		LOT NUMBER:		

At employment, documentation of any history of PPD conversion (positive) must be provided in writing from the individual's physician as well as a chest-Ray report. Any conversion while employed, requires immediate follow-up with a physician including a Chest X-Ray.

DATE OF CONVERSION	X-RAY DATE	FOLLOW-UP/MD CLEARANCE

Practitioner/RN Signature: _____ Date: _____

Lic. No: _____ Stamp:

Pre-employment Annual Assessment Other: _____

Name:	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Address:	DOB:	Title:
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Emergency Contact:	Relationship:
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Emergency Address:	Telephone #:
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INDICATE ILLNESS EXPERIENCED BY Patient			Has Patient had ANY ILLNESS BELOW SINCE LAST ASSESSMENT		
CONDITION	YES	NO	CONDITION	YES	NO
DIABETES			MIGRAINE HEADACHES		
KIDNEY DISEASE			FAINTING OR DIZZINESS		
HEART DISEASE			WEIGHT GAIN/LOSS 15+LBS OR MORE		
HIGH BLOOD PRESSURE			CHANGE IN ENERGY LEVEL		
ARTHRITIS			FREQUENT COUGH		
TUBERCULOSIS			BLOOD IN SPUTUM		
MENTAL ILLNESS			SHORTNESS OF BREATH		
EPILEPSY/CONVULSIONS			CHEST PAIN/PRESSURE IN CHEST		
CANCER			SWELLING IN LEGS/FEET		
			PAIN IN CALF WHEN WALKING		
IS PATIENT CURRENTLY:			CHANGE IN BOWEL HABITS		
ON LONG TERM STEROID THERAPY			BACK PAIN		
ON CHEMOTHERAPY			PAIN WHEN URINATING OR BLOOD IN URINE		
IMMUNO SUPPRESSED			HIGH BLOOD PRESSURE		
			INFECTIOUS DISEASE		
			INCREASED THIRST		
			PERSISTANT SORES OR LUMPS		

LIST ALL PRESCRIPTION MEDICATIONS TAKEN BY PATIENT: _____

Has Patient ever received a BCG Vaccine: <input type="checkbox"/> No <input type="checkbox"/> Yes	LAST CHEST X-RAY ____/____/____
Has Patient converted to a positive PPD: <input type="checkbox"/> No <input type="checkbox"/> Yes	Date: ____/____/____

Has Patient ever received treatment for TB? : <input type="checkbox"/> No <input type="checkbox"/> Yes	When was this? _____
What medications did Patient take? _____	

Has Patient traveled or lived outside the USA in the past year?: No Yes
If yes, where? _____

Is Patient experiencing any of the following:	
Ongoing night sweats: <input type="checkbox"/> No <input type="checkbox"/> Yes	Chronic Fatigue: <input type="checkbox"/> No <input type="checkbox"/> Yes
Unexplained weight loss: <input type="checkbox"/> No <input type="checkbox"/> Yes	Persistent Cough > 3 wks.: <input type="checkbox"/> No <input type="checkbox"/> Yes
Hoarseness: <input type="checkbox"/> No <input type="checkbox"/> Yes	Persistent fever: <input type="checkbox"/> No <input type="checkbox"/> Yes
Coughing up Blood: <input type="checkbox"/> No <input type="checkbox"/> Yes	Shortness of Breath: <input type="checkbox"/> No <input type="checkbox"/> Yes

If yes to any of the questions above, is Patient under treatment? No Yes **With whom**
Diagnosis: _____

Has Patient had the Flu Vaccine this year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Vaccination/Proof attached: _____
<input type="checkbox"/> No Reason: _____	

Name of physician: _____

Address:	Telephone #:
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I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.
I have read the above and declare that Patient has no injury, illness or ailment other than as specifically identified that may interfere with the performance of their job responsibilities. I certify that Patient is not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter their behavior.

Physician Signature/ License Number: _____	Date: _____
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