Good Care Agency, Inc.

EMPLOYEE HEALTH ASSEESSMENT

☐ Annual Assessment ☐ Other:

Name:	Marital Status: ☐ M ☐ S ☐ W ☐ D	Sex: ☐ M ☐ F
Address:	SS #:	Title:

Emergency Contact:	Relationship:
Emergency Address:	Telephone number:

INDICATE ILLNESS EXPERIENCED BY YOU

CONDITION	YES	NO		YES	NO
DIABETES			CHANGE IN ENERGY LEVEL		
KIDNEY DISEASE			FREQUENT COUGH		
HEART DISEASE			Pain when urinating/blood in urine		
HIGH BLOOD PREASSURE			INFECTIOUS DESEASE		
ARTHRITIS			INCREASED THIRST		
TUBERCULOSIS			**TB QUESTIONNAIRE**		
MENTAL ILNESS			CHEST PAIN		
EPILEPSY/CONVULSIONS			LINGERING COUGH		
PAIN IN CALF WHEN WALKING			LOSS OF ENERGY		
BACK PAIN			Weight loss +15 lbs in past year		
CANCER			BLOOD IN SPUTUM		
MIGRAINE HEADACHES			INCREASED SWEATING AT NIGHT		
FAINTING OR DIZZINESS			What was the result of your last TB test? Negative__________ Positive__________		
Weight Loss +15 Lbs in past year					
SHORTNESS OF BREATH			If your test results was positive, were you advised to take any medication? Yes ________ No__________ If "yes" what kind of medication did you take?		
Chest pain/pressure in chest					
SWELLING IN LEGS AND FEET					
CHANGE IN BOWEL HABITS			For how long were you on this medication?______________		
PERSISTANT SORES OR LUMPS					

Do you smoke? ☐ Yes ☐ No if yes, how much?

Do you drink alcoholic beverages? ☐ Yes ☐ No if yes, how much?

Do you take depressant, stimulant, narcotic drugs that alter your behavior? ☐ Yes ☐ No

Do you take prescription medications? ☐ Yes ☐ No if yes, which medications?

Name of your Physician:

Address: Phone:

I have read the above and declare that I have had no injury, illness or ailment other than as specifically identified. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

Signature: Date:

Reviewed by: License #: Date:

Annual TB Questionnaire

(Пожалуйста ответьте на ВСЕ вопросы)

Name (Имя Фамилия) ____

Social Security Number (Сошиал Секьюрити)____________________________

Have you ever been diagnosed with Tuberculosis (TB)? Yes_____ No______
(Болели ли вы когда-нибудь Туберкулёзом?)

Do you experience chest pain? Yes_____ No______
(Бывают ли у вас боли в грудной клетке?)

Do you experience a heavy lingering cough? Yes_____ No______
(Бывает ли у вас тяжёлый продолжительный кашель?)

Do you experience a loss of energy? Yes_____ No______
(Испытываете ли вы тяжёлую усталость?)

Did you experience weight loss (over 15 lbs) in the past year? Yes_____ No______
(Потеряли ли вы больше чем 15 паундов за последний год?)

Do you have blood in your sputum? Yes_____ No______
(Бывает ли у вас кровь в слюне?)

Do you experience an increased sweating at night? Yes_____ No______
(Испитываете ли вы повышенную потливость во время сна?)

What was the result of your last TB test? Positive(+)_____ Negative(-)______
(Каким был результат вашего Манту в прошлом году?)

If your TB test result was positive were you advised to take any medications? Yes_____ No______
(Если ваш Манту был положительный прописали ли вам принимать какие-либо лекарства?)

If "Yes" what kind of medication did you take? ________________________________
(Если "да", то какие лекарства вы принимали?)

How long were you on this medication? ________________________________
(Как долго вы принимали эти лекарства?)

Signature(Подпись)____________________________ Date (Дата)__________