UNIVERSAL MEDICAL RECORD
22 The Cross Road, Cortlandt Manor, New York 10567
Tel. (914) 737-7499 **Fax:** (914) 940-6870
Email recruitment@universalmedicalrecord.com
CONTRACTOR NAME _____

PRE-CONTRACTOR PHYSICAL EXAMINATION AND SCREEN

□ **Pre-Contractor Physical Assessment** □ **Annual Assessment**

Name:_____Job Title:_____
Address:_____Phone No.:_____
Date of Birth: _____ Date of Exam _____

PERSONAL HEALTH HISTORY

1. Past illnesses / Injuries:
   _____
   _____
   _____

2. Allergies:
   _____
   _____
   _____

3. List all medications taken frequently or regularly.
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

4. A.) Smoking : Yes: _____ No: _____ How Often? _____

   B.) Alcohol: Yes:_____ No: _____ How Often? _____
   C.) Substance Abuse: Yes:_____ No: _____ How Often? _____

Please circle any illness or complaints

Asthma	Cancer	Ear Problems	Shortness of Breath
Accidents/Injury	Chest Pain/Heart Problems	Fainting	Skin Rash
Alcohol Problem	Chronic Abd. Pain	Headache/Migraine	Sinus Problems
Allergy	Constipation	HIV/AIDS	Swelling of Ankles
Anemia	Cough	High Blood Pressure	Syphilis
Arthritis	Depression	Kidney Problems	Thyroid Disease
Back Problems	Diabetes	Pneumonia	Tuberculosis
Breast Lump/Surgery	Diarrhea	Rheumatic Fever	Vaginal Discharge/Bleeding
Eye Problems	Seizures	Weight Loss	

Other:_____

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Immunizations / Date			**Titer / Date Result**	
			ATTACH LAB REPORT	
Hepatitis B Vaccine	Yes _____	No___	Hepatitis B Titer ____	_____
Mumps / Varicella	Yes_____	No___	Mumps/Varicella____	_____
Rubeola / Measles	Yes_____	No___	Rubeola/measles____	_____
Rubella	Yes_____	No___	Rubella ____	
Flu Vaccine (within 1 year)	Yes_____	No___		_____
Pneumococcal vaccine	Yes_____	No___		

Tuberculosis (TB) Screening:

(If annual PPD is needed, a 2-step procedure must be done: First, Initial PPD is performed, If negative, a repeat booster PPD test must be performed 1-3 weeks apart)

	Date:	**LOT#**	**Administered By:**	**Date Read:**	**Result-mm**
(Annually)					
PPD #1	_____	_____	_____	_____	_____
PPD #2	_____	_____	_____	_____	_____
Chest X-ray (+) PPD	Last CXR Date:	_____	Result: _____		

Urine Drug Screening Date: _____ Result: _____

Weight: _____ Height: _____ Resp._____Pulse: _____ Blood Pressure: _____

I understand that I must have an annual health screening and annual PPD to retain active services with Universal Medical Record. I hereby give my permission to release the results of any test and/ or information regarding my health status to Universal Medical Record.

_____ _____

Applicant/Contractor Signature Date

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EVALUATION OF SYSTEMS

To Be Completed by Health Examiner: Date:

_____

GENERAL APPEARANCE:_____
_____
_____

System Name	Normal findings?				Comments/Description
Eyes		Yes		No	
Ears		Yes		No	
Nose		Yes		No	
Mouth/Throat		Yes		No	
Head/Face/Neck		Yes		No	
Breasts		Yes		No	
Lungs		Yes		No	
Cardiovascular		Yes		No	
Extremities		Yes		No	
Abdomen		Yes		No	
Gastrointestinal		Yes		No	
Endocrine		Yes		No	
Musculoskeletal		Yes		No	

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Physician Certification

Based on the above information, the Contractor does do not have a communicable disease or other health impairment (such as habituation or addiction to drugs or alcohol) that might present a risk to a resident or otherwise interfere with the performance on his/her duties as a contractor of this facility.

This applicant: is_____, or is not_____, suitable for the position desired.

Physician's Name (*please print*): _____

Physician's License Number: _____

Address: _____

Phone Number: _____

Physician's Office Stamp:

Date: _____