**PRE-EMPLOYMENT PHYSICAL EXAMINATION AND SCREEN**

## Pre-Employment Physical Assessment □ Annual Assessment

Name: Job Title: Address: Phone No.:\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PERSONAL HEALTH HISTORY

* 1. Past illnesses / Injuries:

\_\_\_\_\_\_\_

* 1. Allergies:

\_\_\_\_\_\_\_

* 1. List all medications taken frequently or regularly.

* 1. A.) Smoking : Yes:

No:

How Often?

B.) Alcohol: Yes: No: C.) Substance Abuse: Yes: No:

How Often? 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:

# Immunizations / Date Titer / Date Result

**ATTACH LAB REPORT**

Hepatitis B Vaccine Yes

Mumps / Varicella Yes\_

Rubeola / Measles Yes\_

Rubella Yes\_

Flu Vaccine (within 1 year) Yes\_ Pneumococcal vaccine Yes\_

No No No No No No

Hepatitis B Titer Mumps/Varicella \_\_\_\_\_\_\_\_\_\_\_\_\_ Rubeola/measles Rubella \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 employment 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/Employee Signature Date

EVALUATION OF SYSTEMS

# To Be Completed by Health Examiner: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL APPEARANCE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 |  |

Physician Certification

Based on the above information, the employee **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 an employee 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_