

PRE EMPLOYEE PHYSICAL

Name:	DOB:	Age:
Address:	SS:	Title:

MEDICAL HISTORY

<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Seizure Disorder
Others: _____			

PHYSICAL EXAMINATION

Head/ENT _____	Musculoskeletal _____
Eyes _____	Abdomen _____
Neck _____	Genitourinary _____
Breasts _____	CNS _____
Lungs _____	Comments _____
Cardiovascular _____	_____
Height: _____	Weight: _____
Temp: _____	BP: _____
Pulse: _____	Resp: _____

IMMUNIZATIONS: Rubella Dates: 1. _____ Measles Dates: 1. _____ 2. _____	TITERS: Rubella: Result _____ <input type="checkbox"/> Immune <input type="checkbox"/> Non immune Measles: Result _____ <input type="checkbox"/> Immune <input type="checkbox"/> Non immune
PPD Date planted: _____ Date Read: _____ Result _____ (mm) <input type="checkbox"/> Neg <input type="checkbox"/> Positive	(FOR POSITIVE PPD ONLY) Chest X-ray: Date/Result _____ (Attach report) TB Prophylaxis initiation date: _____ Treatment not recommended: _____ Reason? _____

WORK CLEARANCE:

The above named person is found to be in good mental/physical health. He/She is free from signs and symptoms of habituation or addiction to alcohol, depressants, stimulants, narcotics or other substances that may alter the person's behavior. He/She is free from any condition or communicable disease which could endanger his/her safety as well as the client.

Medical Providers signature: _____ **Date:** _____

Stamp: _____ **License No:** _____

License Number: _____