**PHYSICAL EXAMINATION FORM**

NAME OF INDIVIDUAL EXAMINED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_Re-examination (Required within a one year time period every year of employment)

**THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN, CERTIFIED NURSE PRACTITIONER OR LICENSED PHYSICIAN’S ASSISTANT**

**PART I – Physical Examination**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Height | Weight | Temp | Pulse | Blood Pressure | Respirations |
|  |  |  |  |  |  |
| General Appearance | |  | | | |
| Head and Neck | |  | | | |
| Hearing | |  | | | |
| Vision (At least 20/40 vision  Corrected by glasses if needed) | |  | | | |
| Oral Cavity | |  | | | |
| Respiratory | |  | | | |
| Cardiovascular System | |  | | | |
| Abdomen | |  | | | |
| Musculoskeletal | |  | | | |
| Neurological: | |  | | | |
| Skin | |  | | | |

**PART II – Hepatitis B Vaccination:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Administered |  | Site Administered |  |
| Date Administered |  | Site Administered |  |
| Date Administered |  | Site Administered |  |

-OR-

I have declined the Hepatitis B Vaccination series. Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL EXAMINATION FORM**

(Page 2)

NAME OF INDIVIDUAL EXAMINED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART III – Individual Health History**

Does the individual have any of the following health problems? (please circle. If “Yes, please explain)

|  |  |  |  |
| --- | --- | --- | --- |
| Epilepsy | No | Yes |  |
| Diabetes | No | Yes |  |
| Inadequate Immune Status (Tetanus, Diphtheria, MMR | No | Yes |  |
| Need for more frequent health visits or sick days than  average | No | Yes |  |
| Current drug or alcohol dependence | No | Yes |  |
| Disabling emotional disorder | No | Yes |  |
| Other special medical problems or chronic disease which requires restriction of activity or medication which might affect his/her work role? | No | Yes |  |

**PART IV General Health**

Does this individual have any special medical problems which might interfere with the health of the individual or which might prohibit adequate care for the residents?

|  |  |
| --- | --- |
| No | Yes (please explain) |

**PART V – Communicable Diseases**

Is this individual free from communicable diseases?

|  |  |
| --- | --- |
| Yes | No (please explain) |

If the individual has a communicable disease, but is able to work at a facility, what are the specific precautions to ensure that the spread of disease is prevented?

|  |  |
| --- | --- |
| N/A | Precautions |

**Physician’s Information**

**(Licensed Physician, Certified Nurse Practitioner or Licensed Physician Assistant**

|  |  |
| --- | --- |
| Name |  |
| Medical Family |  |
| Address |  |
| Phone |  |

**Signature of Above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TUBERCULIN TESTING RECORD**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Have you ever had a positive PPD? | No | Yes |
| Have you ever had treatment for TB or preventive therapy | No | Yes |
| Have you had BCG vaccine? | No | Yes |
| Date of last chest x-ray? (if applicable) |  | |

**Mantoux Test Record**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date Given |  | Given By |  | Site |  |
| Manufacturer |  | Exp Date  of Serum |  | Lot # |  |
| Results in mm |  | Read By |  | Date |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date Given |  | Given By |  | Site |  |
| Manufacturer |  | Exp Date  of Serum |  | Lot # |  |
| Results in mm |  | Read By |  | Date |  |

**Physician’s Information**

**(Licensed Physician, Certified Nurse Practitioner or Licensed Physician’s Assistant**

|  |  |
| --- | --- |
| Name |  |
| Medical Facility |  |
| Address |  |
| Telephone Number |  |

**Signature of Above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**