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## Employee Health Examination

Name: \_\_\_\_\_ Date of Physical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Position: \_\_\_\_\_

**Consent for examination and release of information:**

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE DO NOT WRITE BELOW THIS LINE

FOR PHYSICIAN ONLY:

<b>Vital Signs:</b>						
Temp: _____	Pulse: _____	Respiration: _____	BP: _____	Height: _____	Weight: _____	

	WNL (within normal limits)	Positive Findings/Comments
Head		
Eyes		
Ears		
Nose		
Mouth/Teeth		
Neck/Back		
Chest/Breast		
Lungs		
Heart		
Abdomen		
Extremities		
Neuro/Reflex		
Skin		

Comments: \_\_\_\_\_  
 \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

PLEASE DO NOT WRITE BELOW THIS LINE

**Immunizations:** *Lab work MUST be attached*

**Rubella:**

Date: \_\_\_\_\_ Titer Level: \_\_\_\_\_

**Immune**

**Non- Immune**

**Measles:**

Date: \_\_\_\_\_ Titer Level: \_\_\_\_\_

**Immune**

**Non- Immune**

**Mumps:**

Date: \_\_\_\_\_ Titer Level: \_\_\_\_\_

**Immune**

**Non- Immune**

**Varicella:**

Date: \_\_\_\_\_ Titer Level: \_\_\_\_\_

**Immune**

**Non- Immune**

**Hepatitis B:**

Date: \_\_\_\_\_ Titer Level: \_\_\_\_\_

**Immune**

**Non- Immune**

**Influenza:**

Date Vaccine Administered: \_\_\_\_\_ Vaccine Manufacturer: \_\_\_\_\_ Lot No.: \_\_\_\_\_ Site of Injection: \_\_\_\_\_

Administered By: \_\_\_\_\_ Title of Vaccine Administrator: \_\_\_\_\_

**Tuberculosis Screening:** *(Chest X-Ray must be attached for positive PPD or positive IGRA)*

**PPD Test 1** Date Injected: \_\_\_\_\_ Date Read: \_\_\_\_\_ (within last 12 months) Induration: \_\_\_\_\_ (mm) \_\_\_\_\_

**PPD Test 2** Date Injected: \_\_\_\_\_ Date Read: \_\_\_\_\_ (within last 3 months) Induration: \_\_\_\_\_ (mm) \_\_\_\_\_

PPD Administered by: \_\_\_\_\_ Title: \_\_\_\_\_

OR

**Quantiferon** (or other XGA within last 3 months): Date: \_\_\_\_\_ Result: \_\_\_\_\_

**Tuberculosis Assessment:**

Have you had a Positive TB Exposure or Positive TB Skin Test History? (If YES, documentation required) Yes  No

Check the symptoms listed below (must check at least one box):

- |  |   |
|--|---|
| <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Shortness of Breath          |
| <input type="checkbox"/> Lack of Appetite  | <input type="checkbox"/> Low grade fever              |
| <input type="checkbox"/> Weakness          | <input type="checkbox"/> Blood Streaked Sputum        |
| <input type="checkbox"/> FLU like Symptoms | <input type="checkbox"/> Clear, Yellow or Dark Sputum |
| <input type="checkbox"/> Night Sweats      | <input type="checkbox"/> None of the Above            |

**Tuberculosis History:**

Complete this section only if there is TB exposure. Please provide Chest X-Ray radiology report.

Positive Skin Test (documentation required) Date: \_\_\_\_\_

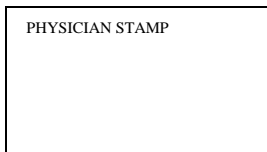
Have you been treated with TB medication?  Yes  No Treatment:  INH  Other: \_\_\_\_\_

Chest X-Ray impression relative to positive PPD:  Positive  Negative

**Employee may work:**

- Without restrictions
- With restrictions *(specify reason and duration)*  
\_\_\_\_\_
- Unable to work *(specify reason and duration)*  
\_\_\_\_\_

PHYSICIAN STAMP



Physician Signature: \_\_\_\_\_

License #: \_\_\_\_\_ Date: \_\_\_\_\_