AdvancedCare
STAFFING

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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:

Vital Signs:

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:	**Immune**	**Non- Immune**
Date: _____ Titer Level: _____	☐	☐
Measles:	**Immune**	**Non- Immune**
Date: _____ Titer Level: _____	☐	☐
Mumps:	**Immune**	**Non- Immune**
Date: _____ Titer Level: _____	☐	☐
Varicella:	**Immune**	**Non- Immune**
Date: _____ Titer Level: _____	☐	☐
Hepatitis B:	**Immune**	**Non- Immune**
Date: _____ Titer Level: _____	☐	☐

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):

☐ Chest Pain	☐ Shortness of Breath
☐ Lack of Appetite	☐ Low grade fever
☐ Weakness	☐ Blood Streaked Sputum
☐ FLU like Symptoms	☐ Clear, Yellow or Dark Sputum
☐ Night Sweats	☐ 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:**_____