



EMPLOYEE PHYSICAL EXAMINATION REPORT
(Please bring this form from your doctor)

Pre-Employment Physical Assessment Annual Assessment Return to Work / LOA Other

Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SS# <input type="text"/> - <input type="text"/> - <input type="text"/>
Home Address:	Marital Status (circle one): M S W D	DOB: <input type="text"/> / <input type="text"/> / <input type="text"/>

PHYSICAL EXAMINATION

Head / ENT _____	Cardiovascular _____
Eyes _____	Musculoskeletal _____
Neck _____	Abdominal _____
Breasts _____	Genitourinary _____
Lungs _____	Central Nervous System _____
Vision: Corrected _____ Uncorrected _____	Height _____
Glasses Needed <input type="checkbox"/> Yes <input type="checkbox"/> No (check one)	Weight _____
Medications (Prescription & OTC medications currently taken) _____	

Allergies _____

Hospitalizations and Surgeries _____

Past Illnesses _____

LABORATORY TEST RESULTS (please attach all LAB reports)

TEST	DATE PERFORMED	RESULTS	LAB VALUE
Rubella Titer	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Non-Immune <input type="checkbox"/> Immune	
Measles Titer	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Non-Immune <input type="checkbox"/> Immune	
PPD (annually)	1. date implemented	1. date read	Results (summary)
	2. date implemented	2. date read	Results (summary)
Chest X-Ray	<input type="text"/> / <input type="text"/> / <input type="text"/>		
Urine Drug Screening	<input type="text"/> / <input type="text"/> / <input type="text"/>		

Tuberculosis Screening Questionnaire:

Does the employee have any of the following possible signs or symptoms of Tuberculosis?

Chills	<input type="checkbox"/> YES <input type="checkbox"/> No	Fever	<input type="checkbox"/> YES <input type="checkbox"/> No	Sputum	<input type="checkbox"/> YES <input type="checkbox"/> No
Appetite Loss	<input type="checkbox"/> YES <input type="checkbox"/> No	Night Sweats	<input type="checkbox"/> YES <input type="checkbox"/> No	Weight Loss	<input type="checkbox"/> YES <input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> YES <input type="checkbox"/> No	Fatigue/Tiredness	<input type="checkbox"/> YES <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> YES <input type="checkbox"/> No
Blood-Strained Sputum	<input type="checkbox"/> YES <input type="checkbox"/> No	Have you come in close contact w/anyone who is/was sick with tuberculosis? <input type="checkbox"/> YES <input type="checkbox"/> No			

This individual is free from any health impairment that is a potential risk to the patient or other employee or which may interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol. _____

This Individual is able to work with the following limitations: _____

This Individual is NOT physically/mentally able to work (specify reason): _____

Physician's Signature _____ Lic. No: _____ Date: _____

Employee's Signature _____