EMPLOYEE PHYSICAL EXAMINATION FORM

□ Pre-Employment Physical Assessment □ Annual Assessment □ ReturntoWork/LOA □Other:_____

Name: _____ **Phone:** _____

Address: _____ **D.O.B.:** _____ **Title:** _____

PHYSICAL EXAMINATION

HEAD/ENT: _____

EYES: _____

NECK: _____

BREASTS: _____

LUNGS: _____

CARDIOVASCULAR: _____

MUSCULOSKELETAL: _____

ABDOMEN: _____

GENITOURINARY: _____

CENTRALNERVOUSSYSTEM: _____

COMMENTS: _____

Height:_____ Weight:_____ B/P:_____ Pulse:_____ Resp:_____ Temp:_____

LABORATORY TEST RESULTS (all lab results must be attached)			
TEST	**DATE**	**RESULT**	
RUBELLA TITER		□ NON-IMMUNE □ IMMUNE LAB VALUE:	
MEASLES TITER		□ NON-IMMUNE □ IMMUNE LAB VALUE:	
PPD(ANNUALLY) 1ST STEP	Date implanted:	Date read:	Result:
2ND STEP	Date implanted:	Date read:	Result:
(OR) QUANTIFERON -TB GOLD			
CHEST X-RAY (+PPD OR TB GOLD)			
DRUG SCREEN			

IMMUNIZATIONS	**DATE**	**DATE**	**DATE**
RUBELLA	**1.**		
RUBEOLA/MEASLES	**1.**	**2.**	
HEPATITES B VACCINE	**1.**	**2.**	**3.**
INFLUENZA VACCINE			

□ 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*):

Please place your stamp here

Physician Signature: **Lic.№:** **Date:**

Tuberculosis Risk Assessment

Tuberculosis Questionnaire

Employee Name: _____ **Date of Evaluation**: _____

DOH of NY requires an annual TB risk assessment is be completed by a licensed practitioner.
If the employee has experienced any of the following symptoms, a chest x-ray is indicated.

1. Chronic Cough	YES	NO
2. Fever	YES	NO
3. Night Sweat	YES	NO
4. Unexplained Weight Loss	YES	NO
5. Hemoptysis (coughing up blood)	YES	NO
6. Hoarseness	YES	NO
7. Wheezing	YES	NO
8. Shortness of Breath	YES	NO
9. Chest Pains	YES	NO

10. Has a history or permanent residence for over 1 month in a country with a high a rate of TB?	YES	NO
11. Is on current or planned immunosuppression therapy?	YES	NO
12. Has had close contact with someone who has had TB?	YES	NO
13. Has been treated for TB infection or a prior diagnosis of active TB infection?	YES	NO

According to the Center for Disease Control & Prevention an initial chest x-ray needs to be completed for any person with a positive PPD-test, and pulmonary symptoms suggestive of TB. Although there are no data to support the use of a routine chest x-ray for persons whom are asymptomatic, more frequent monitoring of TB should be considered for those who are at increased risk for development of active TB.

Date of last chest x-ray: _____

Physician/RN Signature: _____

DOCTOR / RN Stamp below ↓: