BIG HEART HOME CARE

1302 KINGS HWY, 3RD FLOOR, BROOKLYN, NY 11229 EMPLOYEE PHYSICAL EXAMINATION REPORT

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | |  | | | | | |  | DOB: | | | | | Gender: M\_\_ F\_\_ | |
| Address: | | | |  | | | | | |  | Last 4-digit SS #: | | | | | Title: | |
| **PHYSICAL EXAMINATION** | | | | | | | | | | | | | | | | | |
|  | | | NORMAL | | | ABNORAMAL | | |  | | | | | NORMAL | | | ABNORAMAL |
| HEAD/ENT | | |  | | |  | | | ABDOMEN | | | | |  | | |  |
| EYES | | |  | | |  | | | EXTRIMITIES | | | | |  | | |  |
| NECK | | |  | | |  | | | CARDIOVASCULAR | | | | |  | | |  |
| THROAT | | |  | | |  | | | MUSCULOSKELETAL | | | | |  | | |  |
| LUNGS | | |  | | |  | | | SKIN | | | | |  | | |  |
| HEART | | |  | | |  | | | CENTRAL NERVOUS SYSTEM | | | | |  | | |  |
| HT | WT | | | | B/P: | | | | PULSE: | | | | RESP: | | TEMP: | | |
| TUBERCULOSIS SKIN TESTING (PPD SKIN TESTING)  **\*\*\*(If the PPD result is negative, administer PPD #2) \*\*\***  **THE TWO-STEP PPD OR QUANTIFERON TB BLOOD TESTING METHOD IS REQUIRED FOR PRE-EMPLOYMENT** | | | | | | | | | | | | | | | | | |
| PPD step 1 | | 1. DATE IMPLANTED: | | | | | 1. DATE READ: | | | | | Results (mm induration) | | | [ ] Positive  [ ] Negative | | |
| PPD step 2 | | 2. DATE IMPLANTED: | | | | | 2. DATE READ: | | | | | Results (mm induration) | | | [ ] Positive  [ ] Negative | | |
| Quantiferon TB Blood Test | | | | | | | DATE: | | | | | RESULTS: [ ] Positive [ ] Negative | | | | | |
| Chest x-Ray (For + PPD only) | | | | | | | DATE: | | | | | RESULTS: [ ] Positive [ ] Negative | | | | | |
| TB SCREENING QUESTIONAIRE (Annually for + PPD only) | | | | | | | | | | | | DATE: | | | | | |
| URINE DRUG SCREENING  **\*\*\* (Attacha Laboratory Report) \*\*\***  A 8-PANEL DRUG SCREEN IS REQUIRED ANNUALLY | | | | | | | | | | | | | | | | | |
| 8 PANEL DRUG SCREENING | | | | | | | DATE: | | | | | | | | | | |
| SEASONAL INLUENZA VACCINE  **\*\*\*(lf exempt, provide proof)\*\*\***  A SEASONAL INFLUENZA VACCINATION REQUIRED ANNUALLY | | | | | | | | | | | | | | | | | |
| INFLUENZA VACCINE | | | | | | | DATE: | | | | | | | | | | |
| IMMUNIZATIONS(REQUIRED FOR PRE-EMPLOYMENT ONLY)  **\*\*\*(Please attach Laboratory Report)\*\*\*** | | | | | | | | | | | | | | | | | |
| MUMPS | | DATE IMPLANTED | | | | | | [ ] NON-IMMUNE [ ] IMMUNE LAB VALUE: | | | | | | | | | |
| MEASLES (RUBEOLA) | | DATE IMPLANTED: | | | | | | [ ] NON-IMMUNE [ ] IMMUNE LAB VALUE: | | | | | | | | | |
| RUBELLA | | DATE IMPLANTED: | | | | | | [ ] NON-IMMUNE [ ] IMMUNE LAB VALUE: | | | | | | | | | |
| VARICELLA | | DATE IMPLANTED: | | | | | | [ ] NON-IMMUNE [ ] IMMUNE LAB VALUE: | | | | | | | | | |
| [ ] This individual is free from a health impairment which is of potential or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter his/her behavior.  [ ]This individual is able to work with the following; imitations:  [ ]This individual is not physically/mentally able to work (specify)  Physician's Name/Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Licence #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |