BIG HEART HOME CARE

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

Tel: 347.542.4150 Fax: 347 5424152

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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: |
| URINE DRUG SCREENING**\*\*\* (AttachaLaboratory Report) \*\*\***A 8-PANEL DRUG SCREEN IS REQUIRED ANNUALLY |
| 8 PANEL DRUG SCREENING | DATE: |
| **ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE**Have you ever had a test for Tuberculosis? Yes \_\_\_\_\_ No \_\_\_\_\_PPD/Mantoux Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Chest X-Ray Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatment Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you currently have any of the following symptoms?Symptoms Yes No CommentsWeakness \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fatigue \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lack of Appetite \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight Loss \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Low Grade Fever \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Night Sweats \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Flu-Like Symptoms \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Chest Pain \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Shortness of Breath \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Persistent Cough \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Streaked Sputum \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Color of Sputum (CIRCLE) Clear Yellow Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever been exposed to anyone exhibiting the above signs or symptoms, or someone who has had active tuberculosis? Yes: \_\_\_\_\_ No: \_\_\_\_\_**If I should notice any of the above signs or symptoms, I understand that I am to immediately notify my Physician and my Employer.** |
| INFLUENZA VACCINE | DATE: |
| [ ] 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: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

Revised 01/2021