BIG HEART HOME CARE

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

Tel: 347.542.4150 Fax: 347 5424152

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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: | | |
| 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 Comments  Weakness \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |

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