All Heart Homecare Agency

1664 East 14 Street, Ste 201, Brooklyn, NY 11229
Tel: 718.627.0300 Fax: 718.627.0330

EMPLOYEE PHYSICAL EXAMINATION REPORT

(Please bring this form from your doctor)

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

Name	Sex: __ M __ F	SS# _ _ _ - _ _ - _ _ _ _
Home Address:	Martial Status (circle one): M S W D	DOB: _ _ / _ _ / _ _ _ _

PHYSICAL EXAMINATION

Head / ENT _____ Cardiovascular _____

Eyes _____ Musculoskeletal _____

Neck _____ Abdominal _____

Breasts _____ Genitourinary _____

Lungs _____ Central Nervous System _____

Vision: Corrected_____ Uncorrected_____ Height _____

Glasses Needed ___Yes ___ 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	__ / __ / ____	__ Non-Immune ___Immune	
Measles Titer	__ / __ / ____	__ Non-Immune ___Immune	
PPD (annually)	1. date implemented	1. date read	Results (summary)
	2. date implemented	2. date read	Results (summary)
Chest X-Ray	__ / __ / ____		
Urine Drug Screening	__ / __ / ____		

Tuberculosis Screening Questionnare:

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

Chills ___YES ___No	Fever ___YES ___No	Sputum ___YES ___No
Appetite Loss ___YES ___No	Night Sweats ___YES ___No	Weight Loss ___YES ___No
Chronic Cough ___YES ___No	Fatigue/Tiredness ___YES ___No	Shortness of Breath ___YES ___No
Blood-Streaked Sputum ___YES ___No	Have you come in close contact w/anyone who is/was sick with tuberculosis? ___YES ___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 _____