

**MEDICAL/PHYSICAL EXAMINATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**A. Family History**

- 1. Tuberculosis \_\_\_\_\_
- 2. Nervous Disorder \_\_\_\_\_
- 3. Other Diseases \_\_\_\_\_

**B. Past History**

- 1. Gain or Loss of Weight \_\_\_\_\_ Amount \_\_\_\_\_
- 2. Any Extended Sickness (past 5 yrs. ) \_\_\_\_\_
- 3. Circle applicable data:  
 TB    Diabetes    Cancer    Rheumatic Fever    Epilepsy  
 Allergies    Hypertension    Addiction to: Drugs Alcohol
- 4. Any nervous condition \_\_\_\_\_
- 5. Serious Accidents \_\_\_\_\_
- 6. Operations \_\_\_\_\_
- 7. Back Problems \_\_\_\_\_
- 8. Other Orthopedic Problems \_\_\_\_\_
- 9. Venereal Disease \_\_\_\_\_
- 10. Description of any other physical condition, medical condition, disability that would limit or impact in any way your ability to work with, move, or transfer patients.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**C. Applicants Signature** \_\_\_\_\_

**D. Physical Examination:**

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Temp \_\_\_\_\_ BP \_\_\_\_\_  
 General Appearance \_\_\_\_\_  
 Lymph Nodes \_\_\_\_\_ Extremities \_\_\_\_\_  
 Vision \_\_\_\_\_ Hearing \_\_\_\_\_  
 Breasts and Genitalia \_\_\_\_\_  
 Nose and Throat \_\_\_\_\_  
 Lungs \_\_\_\_\_ Heart \_\_\_\_\_

# MEDICAL/PHYSICAL EXAMINATION

Abdomen \_\_\_\_\_ Eyes \_\_\_\_\_  
Ears \_\_\_\_\_  
Neurological Status \_\_\_\_\_  
Any Special Medical or Physical Needs? \_\_\_\_\_  
Abnormalities Noted: \_\_\_\_\_

## Hx. of TB Exposure

1. Negative Mantoux test results within past year? \_\_\_\_\_
2. Date of Mantoux Test. \_\_\_\_\_
3. If Mantoux Test positive, Date of follow-up? \_\_\_\_\_
  - a. Chest X-ray \_\_\_\_\_ Results: pos. \_\_\_\_\_ neg. \_\_\_\_\_

## E. Part 1. Communicable Disease Disclosure:

\_\_\_\_\_ has been examined by  
(Employee name)  
Dr. \_\_\_\_\_ on \_\_\_\_\_ 20\_\_\_\_\_  
(Physician name) (Date)

\_\_\_\_\_ is free of communicable disease and serious health problems.  
(Employee name) \* Pending PPD Testing  
\_\_\_\_\_  
(Physician signature) (Date)

F. **Part II.** Upon examination and testing, the employee was found to have a serious medical problem or communicable disease.

\_\_\_\_\_ The person will not pose a serious threat to health or safety or well being of the individual.

\_\_\_\_\_ Specific instructions and precautions to be taken for the protection of the individual at home.

Precautions needed to assure that a disease is not spread to individuals depends on whether a person is likely to spread the disease to an individual in the course of their work.

G. **Print examiner's name:** \_\_\_\_\_  
**Address of the Examiner:** \_\_\_\_\_  
\_\_\_\_\_  
**Phone Number:** \_\_\_\_\_