

**Annual Health Assessment (Physical examination)**

Name: \_\_\_\_\_ RN/LPN/PT/OT/COTA/CSW/SLP/SI  
Address: \_\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Phone: \_\_\_\_\_

**I. Past Medical /Psychological History**

Tuberculosis: no ( ) Yes ( )  
Diabetes: no ( ) Yes ( )  
Heart or Cardiovascular Disease: no ( ) Yes ( )  
Hypertension: no ( ) Yes ( )  
Cancer: no ( ) Yes ( )  
Kidney Disease: no ( ) Yes ( )  
Allergies: no ( ) Yes ( ) If yes, state \_\_\_\_\_  
Epilepsy or Seizure disorder: no ( ) Yes ( )  
Drug/Alcohol abuse or addiction: no ( ) Yes ( )  
Psychiatric or Behavioral Disorder: no ( ) Yes ( )  
Other \_\_\_\_\_ Are you now taking medications? If so, for what \_\_\_\_\_

**Examiner, please complete the following:**

**II. Mandatory Immunizations and Lab tests. Exact titre number must be given as requested.**

Diphtheria \_\_\_\_\_ (Unless given in the last 10 years)  
Tetanus \_\_\_\_\_ (Unless given in the last 10 years)  
PPD (Mantoux) \_\_\_\_\_ Date \_\_\_\_\_ Results: \_\_\_\_\_ Date: \_\_\_\_\_  
Rubella titre \_\_\_\_\_ Or screen \_\_\_\_\_ Date \_\_\_\_\_  
Results: ( ) immune ( ) not immune ( ) rubella vaccine (If needed): \_\_\_\_\_  
Rubeola titre \_\_\_\_\_ Or screen \_\_\_\_\_ Date \_\_\_\_\_  
Results: ( ) immune ( ) not immune ( ) rubeola vaccine (If needed): \_\_\_\_\_  
Hepatitis B: ( ) immune ( ) not immune ( ) immunization contraindicated  
Vaccine dates: \_\_\_\_\_

**III. Lab Tests**

CBC: \_\_\_\_\_ Results \_\_\_\_\_ Date \_\_\_\_\_  
Urinalysis: \_\_\_\_\_ Results: \_\_\_\_\_ Date \_\_\_\_\_

\*\*\* Chest X-RAY Mandatory if PPD (MANTOUX) is positive!!!

**IV. Review of Systems by Examiner:**

Head/Neck \_\_\_\_\_  
EENT \_\_\_\_\_  
Resp \_\_\_\_\_  
Cardiovascular \_\_\_\_\_  
ABD - GI \_\_\_\_\_  
GU \_\_\_\_\_  
Musc-skel \_\_\_\_\_  
Neuro \_\_\_\_\_  
Endocrine \_\_\_\_\_  
Skin \_\_\_\_\_

**V. Medical Examiner:**

I hereby certify that the above named patient does not have any limitations for employment in the health care field and contract with patient and other staff. There is no health impairment present that is of potential risk to the employee, patient, family or other employees, or that may interfere with the performance of duties.

*Physician's signature:* \_\_\_\_\_ *Physician's name* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Date* \_\_\_\_\_

*Phone:* \_\_\_\_\_