ABSOLUTE HOME HEALTH & HOSPICE

EMPLOYEE HEALTH EXAMINATION

NAME:_____ DATE OF BIRTH_____

SEX: M F

ADDRESS:

_____

APPLICANT: HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
__	__	ALLERGIES	__	__	HERNIA	__	__	ASTHMA
__	__	HIGH BLOOD PRESSURE	__	__	CHRONIC BACK PAIN	__	__	INJURIES
__	__	CHEST PAINS	__	__	OPERATIONS	__	__	DIABETES
__	__	RHEUMATIC FEVER	__	__	EPILEPSY	__	__	SKIN DISEASE
__	__	OTHER SERIOS ILLNESS	__	__	TUBERCULOSIS	__	__	HEARING LOSS
__	__	CHICKEN POX	__	__	TRANSFUSIONS	__	__	VACCINE:
__	__	RUBELLA (GERMAN MEASLES)	__	__	TETANUS TOXOID	__	__	HEP B(LAST DOSE)

_____

STATE DETAILS FOR ITEMS CHECKED YES:_____

_____

I CERTIFY THAT TO MY KNOWLEDGE I HAVE NO INJURY, ILLNESS OR AILMENT OTHER THAN SPECIFICALLY NOTED AND GIVE THE EXAMINING PHYSICAIN PERMISSION TO SUBMIT A REPORT TO MY EMPLOYER.

DATE:_____ SIGNATURE:_____

TO BE COMPLETED BY PHYSICIAN

HEIGHT:_____ BLOOD PRESSURE:_____ TEMPERATURE:_____

WEIGHT:_____ PULSE:_____ RESPIRATION:_____

PHYSICAL FINDING:

EENT:_____ ABDOMEN_____

HEART:_____ EXTREMITIES:_____

LUNG:_____

GENERAL OBSERVATIONS:_____

PPD DATE:_____ CHECKED: _____/_____MM RUBELLA TITER:_____

HEPATITIES SCREENING:_____ VARICELLA ANTIBADIES: _____

I HAVE FOUND NO INDICATION OF ANY CONDITION WHICH MIGHT REPRESENT A POSSIBLE HAZARD TO THE HEALTH OF PARTICIPANT(S) OR OTHER EMPLOYER(S)

DATE:_____ EXAMINER'S SIGNATURE:_____ PHONE:_____

EXAMINER'S NAME:_____ ADDRESS:_____

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