All Heart
Homecare Agency

1660 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
Chronic Cough ___YES ___No	Night Sweats ___YES ___No	Weight Loss ___YES ___No
Other:		

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: ____________

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Employee Name: ______________________________

Annual Tuberculosis Screening Questionnaire

1. Do you currently have any of the following signs or symptoms?

	YES	NO	COMMENTS
Weakness	____	____	____________
Fatigue	____	____	____________
Lack of Appetite	____	____	____________
Weight Loss	____	____	____________
Low Grade Fever	____	____	____________
Night Sweats	____	____	____________
Flu-Like Symptoms	____	____	____________
Chest Pain	____	____	____________
Shotness of Breath	____	____	____________
Persistent Cough	____	____	____________
Blood-Streaked Sputum	____	____	____________
Yellow or Dark Sputum	____	____	____________

2. Have you been exposed to anyone with the above signs or symptoms or who has had tuberculosis?

Yes ☐ No ☐

If I should notice any of the above signs or symptoms, I will notify my Primary Care Provider and my agency immediately.

Employee Signature ______________________ Date:

Primary Care Provider Signature: ______________ Date:

(stamp)

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Influenza Vaccination Form

Name: ____________________

Date of Birth: ____________________ Sex: Female Male

Allergies: No Yes Specify: ____________________

Please answer the following questions:

1. Are you sick or do you have a fever today?	Yes	No	Don't Know
2. Have you ever had any reaction to influenza vaccine in the past, including Guillain-Barre syndrome?	Yes	No	Don't Know
3. Are you currently pregnant?	Yes	No	Don't Know

Consent

I have read the provided information about influenza vaccination or had such explained to me. I have had the opportunity to ask questions which have been answered to my satisfaction. I understand the benefits and risks of the vaccination and hereby request to be given the influenza vaccine.

Signature ____________________ Date ____________

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Influenza Vaccine Administration

Type of Vaccine ____________________ Dosage ____________

Lot # ____________________ Expiration Date ____________

Administered by ____________________

Address ____________________

Signature ____________________ Date ____________

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