HEALTH RECORD

I. INFORMATION

Last Name | First Name | MI | Sex | Date of Birth

Home Phone | Cell Phone | Work Phone

Mailing Address: Street | City | State | Zip

Emergency Contact

Name: Relationship:

Address:

Telephone number: (Home) (Work) (Cell)

II. TUBERCULOSIS SKIN TEST RESULTS (Testing required per Regulations of the Department of Health)

Tuberculosis/PPD Test (if required)

Two Step PPD	Date Given		Yes		No	Date Checked
1st Step		Positive	☐	Negative	☐	
2nd Step		Positive	☐	Negative	☐	

Alternative PPD Assessment (if required)

X-Ray		Positive	☐	Negative	☐	PLEASE ATTACH COPY OF RESULTS

QuantiFERON Gold Test (if required)

QuantiFERON		Positive	☐	Negative	☐	PLEASE ATTACH COPY OF RESULTS

II. IMMUNIZATION HISTORY (Recommended, but not mandated by law)

Have You Received Hepatitis B vaccination? If yes, date: _____

IV. MEDICAL CONDITIONS (✓)

	Yes	No	If Yes, Explain:
Allergies.....	☐	☐	_____
Asthma.....	☐	☐	_____
Cardiac.....	☐	☐	_____
Chemical Dependency	☐	☐	_____
Drugs.....	☐	☐	_____
Alcohol.....	☐	☐	_____
Diabetes Mellitus	☐	☐	_____
Gastrointestinal Disorder	☐	☐	_____

	Yes	No	If Yes, Explain
Hearing Disorder.....	☐	☐	_____
Hypertension.....	☐	☐	_____
Neuromuscular Disorder.	☐	☐	_____
Orthopedic Condition.....	☐	☐	_____
Respiratory Illness.....	☐	☐	_____
Seizure Disorder.....	☐	☐	_____
Skin Disorder.....	☐	☐	_____
Vision Disorder.....	☐	☐	_____
Other (Specify).....	☐	☐	_____

V. PHYSICAL EXAMINATION (✓)

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: RL				
Eyes – Color Vision				
Ears – Hearing (dB) RL				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc.				
Lungs – Adventious Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify _____

Are there any special equipment or accommodations needed to enable this person to perform their duties?
If so, specify _____

_____

Physician Name (Print) **Signature of Examiner** **Date**

_____

Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

_____ _____

Signature of Employee **Date**