# J&N EXQUISITE HOMECARE INC.

**HEALTH HISTORY AND PHYSICAL**

NAME: AGE: DOB:

ADDRESS:

## HEALTH HISTORY

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Y | N |  | Y | N |  | Y | N |
| Asthma |  |  | Bleeding Disorders |  |  | Rheumatic Fever |  |  |
| Hypertension |  |  | Hypotension |  |  | Muscular Disease |  |  |
| Head or Spinal Injuries |  |  | Cancer |  |  | Ulcers |  |  |
| Psychiatric Problems |  |  | Smoker (# PPD ) |  |  | Bronchitis/COPD |  |  |
| Emotional Disorders |  |  | Tuberculosis |  |  | Syphilis/Chlamydia |  |  |
| Heart Disease |  |  | Herpes/Gonorrhea |  |  | Diabetes |  |  |
| Chest pain |  |  | Kidney Disease |  |  | Sores that don’t heal |  |  |
| Shortness of Breath |  |  | Back pain or injury |  |  | Unexplained fatigue |  |  |
| Hernia |  |  | Wears glasses or contact lenses |  |  | Loss/Gain 20 lbs. or more in year |  |  |
| Dizziness |  |  | Frequent headaches |  |  | Recent change in bowl pattern |  |  |

Allergies Hospitalizations/surgeries

**PHYSICAL EXAMINATION**

Vital Signs: B.P. Pulse Respirations Weigh Height

Eyes: Fundus Right Left Accommodation Snellen Test R- L-

Nose/ Sinuses: Ears: Right Left

Skin/Nails/Hair: Head:

Mouth/Teeth: Thyroid:

Carotid: Lymph:

Chest/Lungs CV - Heart Sounds:

Abdomen: Rectal Exam:

Musculoskeletal System: Upper Lower Reflexes

Neurological System: GU/GYN

**LABORATORY TESTS/SCREENING**

PPD (Mantoux) Date Planted Read Results By CHEST X-RAY Reason Date Results \_\_\_\_\_\_\_\_

RUBELLA Titer Date Immunization Date RUBEOLA Titer Date Immunization Date \_\_\_\_\_\_\_\_\_\_\_

TETANUS Hep B dates: \_\_\_\_\_\_/ \_\_\_\_\_\_/\_\_\_\_\_ OTHER (specify) name/date:

BLOOD WORK URINALYSIS

Indication of habituation or addiction which may alter behavior [ ] No [ ] if Yes, explain below.

[ ] I have examined the above named individual and find no physical, behavioral or psychological impediment to he/she providing direct patient care.

[ ] I HAVE found the following condition(s) which would appear to prevent this person from fulfilling the requirements for working in the home care field and have recommended follow up:

**COMMENTS**

Physician Signature Exam Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Tel.# License #

Org. 9.09