Life's Touch Home Health - EMPLOYEE PHYSICAL FORM

Name ____ AGE _____ WT _____ HT _____

Facility ____ B/P _____ T _____ P _____ R _____

1. When was the last time you were sick?

   Date: ___/ ___/ _____ Illness: ____

2. Are you taking any medication now or under treatment for any disorder? Please list medications.

   ____

3. Have you ever had any of the following?

YES	NO	
❑	❑	Blackouts, dizzy spells or severe headaches?
❑	❑	Convulsions?
❑	❑	Any chronic illness?
❑	❑	Persistent cough or fever?
❑	❑	Recent weight loss?
❑	❑	Jaundice or fiver disease?
❑	❑	Diabetes or sugar in urine?
❑	❑	Arthritis or joint disease?
❑	❑	Skin disorders?
❑	❑	Disorder of vision or hearing?
❑	❑	Heart of lung disease?
❑	❑	High blood pressure?
❑	❑	Alcohol or other drug problems
❑	❑	Allergies? If yes, list ____

4. Have you ever received any Hepatitis B vaccinations?

YES	NO	Dates: ________________
❑	❑	________________

5. Have you ever had a back injury or other serious physical injury? If yes, please give details of such injury and current status including physician's statement. ____

   ____

   I certify that the above statements are true and correct:

____
EMPLOYEE'S SIGNATURE

This is to certify that the employee is free from communicable diseases in the communicable state, and from health handicaps which might disqualify him/her from employment.

Further, that the Hepatitis B vaccination series is indicted and there are no medical contradictions to the receipt of the Hepatitis B vaccination series.

2-Step Mantoux Skin Test or Chest X-Ray on:

Date: ___/ ___/ _______	Date: ___/___/______
Read: ___/ ___/ _______	Read: ___/ ___/ _____
Results: ______________	Results: _________________

Comments: ____

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PHYSICIAN SIGNATURE