MARQUIS HOME CARE
230 N. Main Street, Spring Valley, NY 10977 Phone: (845) 363-8140 Fax: (845) 363-8141

EMPLOYEE'S PHYSICAL EXAM FORM TO BE COMPLETED BY PHYSICIAN

Dear Doctor: Please complete this form on the following person. This information is mandatory for employment in the health field.

NAME _____ DATE OF BIRTH _____ GENDER: _____

HISTORY

	YES	NO		YES	NO		YES	NO
Heart Disease	[ ]	[ ]	Hepatitis	[ ]	[ ]	Diabetes	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Alcohol/Drug	[ ]	[ ]	Thyroid	[ ]	[ ]
Back Problems, Injuries	[ ]	[ ]	Anemia	[ ]	[ ]	Seizure Disorder	[ ]	[ ]
Arthritis	[ ]	[ ]	Asthma	[ ]	[ ]	Hernia	[ ]	[ ]
Emotional or Mental Problems	[ ]	[ ]	Cancer	[ ]	[ ]	Poor Hearing	[ ]	[ ]
Poor Vision	[ ]	[ ]	Tuberculosis	[ ]	[ ]	Allergies	[ ]	[ ]

If yes, please describe: _____

_____

Previous medical illness or surgical procedures: _____

_____

PHYSICAL EXAM

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Respirations: _____

SKIN _____ HEART _____

HEAD _____ LUNGS _____

EYES _____ ABDOMEN _____

ENT _____ BACK _____

NECK _____ EXTREMITIES _____

NEUROLOGIC _____

Please describe abnormalities (include any lifting restrictions): _____

_____

IMMUNIZATION HISTORY

(only those that are checked off are to be administered)

[ ] PPD (Mantoux): Date Implanted _____ Date Read _____ Results _____(mm) Interpretation _____

(For Positive PPD Only)

[ ] Chest X-Ray: Date/Result: _____ (Attach original report)

TB Prophylaxis initiation date: _____

Treatment Not Recommended: _____ Reason: _____

[ ] Rubella Titer (Attach original lab report): _____

[ ] Rubeola Titer (Attach original lab report): _____ **OR**

[ ] Rubella Immunization (Only if titer shows no immunity): _____

[ ] Rubeola Immunization (Only if titer shows no immunity): 1st Dose _____ 2nd Dose _____

[ ] Influenza Vaccine Date: _____Lot #_____

WORK CLEARANCE

The above named person is found to be in good mental/physical health. He/she is free from signs and symptoms of habituation or addiction to alcohol, depressants, stimulants, narcotics or other substances that may alter the person's behavior. He/she is free from any condition or communicable disease which could endanger his/her safety as well as the client.

Physician Signature _____ Exam Date _____

Stamp: _____ License No. _____