ACCENT HEALTH CARE SERVICES, INC.

PHYSICAL EXAMINATION FORM

Employee____ Date of Physical_______________

Date of Birth____Allergies_____________________

Medical History____

____

Medications____

____

Physical Assessment:

Height______________________ Weight___________________________

Skin__________________ BP__________________ P________________ R_______________

EENT____

Neck____ Mouth___________________________

Lymph Nodes__________________________________ Breasts___________________________

Heart____ Edema___________________________

Gen. Circulation____

Lungs____ Abdomen_________________________

Skeletal/ Muscular Status____

Neurological Status____

Symptoms of drug/ alcohol
addiction____

Mental Health Status____

General Health Status____

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PPD: Date given__________________________ Location______________________________

Lot number__________________________ Expiration Date________________________

Manufacturer____

Date read____________________________ By__________________________________

Results____

Chest X-ray for positive PPD

Date_______________________________ Results_______________________________

Rubella Proof of immunity

Vaccine Date________________________ lot#__________________________________

Exp. Date___________________________

Titer Date___________________________ Results_______________________________

Rubeola Proof of immunity

Vaccine #1 Date _______________________ lot#_________________________________

Exp. Date______________________________

Vaccine #2 Date________________________ lot#_________________________________

Exp. Date______________________________

Titer Date_____________________________Results______________________________

The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addition to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior

____ ______________________________

Physician Signature Date

Rev 11/16
Rev 05/18 SB