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☐ Pre-Employment Physical

The physical examination must have lab reports for Rubella, Rubeola, and drug screen, must also have the Dr.'s signature, license, stamp, & date

Name:	Marital Status: M ☐ S ☐ W ☐ D ☐	Sex: M ☐ F ☐
Address:	SS#:	Title:

PHYSICAL EXAMINATION ↓	TB QUESTIONNAIRE	Yes	No		Yes	No
HEAD/ENT:						
EYES:	Weakness			Persistent Cough		
NECK:	Fatigue			Blood Streaked Sputum		
BREASTS:	Lack of Appetite			Have you ever had a test for Tuberculosis?		
LUNGS:	Weight Loss			Have you ever been exposed to someone who has had active tuberculosis?		
CARDIOVASCULAR:	Low Grade Fever			If yes, did you receive treatment?		
MUSCULARSKELETAL:	Night Sweats			Color of Sputum (CIRCLE): Clear Yellow Other: ________		
ABDOMEN:	Flu-Like Symptoms					
GENITOURINARY:	Chest Pain					
CENTRAL NERVOUS SYSTEM:	Shortness of Breath					

For Conversions Only:

OUTCOME: (Check one box only)

- ☐ LTBI treatment prescribed
- ☐ Pt. evaluated as TB suspect
- ☐ No treatment needed (due to_______________)
- ☐ No treatment indicated (Low TB risk)
- ☐ Treatment not advised due to high risk of hepatitis
- ☐ Type of Treatment: _________________________
- ☐ History of BCG
- ☐ Other: _________________________________

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

* * * LABORATORY TEST RESULTS MUST BE ACCOMPANIED BY LAB REPORTS * * *

TEST	DATE PERFORMED and RESULTS		TEST	DATE PERFORMED and RESULTS	
1ST PPD DATE IMPLANTED	DATE READ	RESULTS (mm x mm)	2ND PPD DATE IMPLANTED	DATE READ	RESULTS (mm x mm)
CHEST X-RAY (+PPD)	DATE:		RESULTS and COPY OF REPORT		
RUBELLA	DATE:	☐ I MMUNE ☐ NON-IMMUNE	RUBEOLA	DATE:	☐ I MMUNE ☐ NON-IMMUNE
DRUG SCREEN (5-10 panel):	DATE:		RESULTS, COMMENTS & LAB REPORT		
FLU SHOT:	DATE:				
HEPATITITS B VACCINE:	1.		2.		3.

☐ This individual is free from any health impairment that is a potential risk to the patient or to other employee or which may interfere with the performance of his/her duties including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs, or substances which may alter the individual's behavior.

☐ This individual is able to work with the following limitations: ______________________________

☐ This individual is not physically/mentally able to work. *(specify reason)*:__________________________

Physician Signature:	Lic. No. & Stamp	Date: