NAME OF INSTITUTION	**EMPLOYEE HEALTH EXAMINATION**

TO BE FILLED OUT BY EMPLOYEE'S PHYSICIAN

I have examined Mr. / Mrs. / Miss _____ (Last Name, First, Middle)

who is applying for the position of _____

Blood Pressure: _____ Pulse: _____ Temp: _____
Back Bending: _____ Straight Leg Bending: _____
Rising From Supine: _____ Extremities: _____
Neurologic-Knee Jerk: (R) _____ (L) _____ Ankle Jerk (R) _____ (L) _____

I have found no condition that appears to prevent him/her from performing the duties of the position applied for with the exception of the following:

_____

_____

This health questionnaire and health examination is for employment purposes only and is not intended to be a complete physical. I found that the person is sufficiently free of disease to perform assigned duties and does not have any health condition that would create a hazard for himself, fellow employees, or residents or visitors.

Date _____

Signed _____ M.D.

_____
Address

TESTS

Purified Protein Derivative Test _____ **DATE PERFORMED** _____ **RESULTS / DATE**

Chest X-ray Test _____ **DATE PERFORMED** _____ **RESULTS / DATE**

_____ _____
BY WHOM PHYSICIANS SIGNATURE

Stool Culture
(Only when required by law)

_____

_____

EMPLOYEE'S HEALTH QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ INITIAL _____ SMWD _____ AGE _____ SEX _____

Address _____ Telephone _____

Position Applied For _____ Date _____

Family Physician _____ Date and reason for last visit _____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING (Check "Yes" or "No" after each question):

Disease of:	Yes	No
Brain	☐	☐
Eyes	☐	☐
Ears	☐	☐
Nose	☐	☐
Throat	☐	☐
Heart	☐	☐
Lungs	☐	☐
Stomach	☐	☐
Intestines	☐	☐
Liver	☐	☐
Spleen	☐	☐
Gallbladder	☐	☐
Kidneys	☐	☐
Bladder	☐	☐
Bone	☐	☐
Joints	☐	☐
Back (Spine)	☐	☐
Skin	☐	☐
Lymph nodes	☐	☐
Genitals	☐	☐
Dizziness	☐	☐

	Yes	No
Frequent Headaches	☐	☐
Deafness	☐	☐
Running Ears	☐	☐
Freq. sore throat	☐	☐
Frequent colds	☐	☐
Fainting spells	☐	☐
Chest pains	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐
Coughing up blood	☐	☐
Palpitations	☐	☐
Allergies	☐	☐
Poor appetite	☐	☐
Chronic indigestion	☐	☐
Recurrent nausea	☐	☐
Recurrent vomiting	☐	☐
Vomiting of blood	☐	☐
Chronic constipation	☐	☐
Black or bloody bowel movements	☐	☐

	Yes	No
Freq. or painful urination	☐	☐
Blood in urine	☐	☐
Swollen ankles	☐	☐
High blood pressure	☐	☐
Jaundice	☐	☐
Hernia	☐	☐
Stomach ulcers	☐	☐
Pneumonia	☐	☐
Pleurisy	☐	☐
Kidney stones	☐	☐
Piles	☐	☐
Fits or convulsions	☐	☐
Tuberculosis	☐	☐
Bronchitis	☐	☐
Nephritis	☐	☐
Malaria	☐	☐
Rheumatic fever	☐	☐
Paralysis	☐	☐
Cancer or tumor	☐	☐
Asthma	☐	☐

	Yes	No
Hay fever	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Rheumatism	☐	☐
Nervous breakdown	☐	☐
Painful flat feet	☐	☐
Backaches	☐	☐
Chronic sinus infection	☐	☐
Injuries	☐	☐
Operations	☐	☐
Other serious illness	☐	☐

Height _____

Weight _____

Explain Yes answers: _____

State details of illnesses, injuries, or operations: _____

In case of accident or emergency, are you currently taking any medications Yes ☐ No ☐ If yes, please explain _____

I understand a Purified Protein Derivative test is required for all new employees in this institution by California State Law. A Chest x-ray may also be required in the event of positive Purified Protein Derivative test results. I further agree to take such tests upon hire and annually thereafter.

I, THE UNDERSIGNED, CERTIFY THE ABOVE ANSWERS ARE TRUE, AND GIVE THE EXAMINING PHYSICIAN PERMISSION TO SUBMIT A REPORT TO THE EMPLOYER.

Date _____ ,20 _____ Signed: _____