CARING
PROFESSIONALS, INC.
LICENSED HOMECARE AGENCY

# CARING ASSISTANTS PHYSICAL EXAMINATION

NAME_____ PHONE_____ TODAYS DATE_____

ADDRESS_____

## I. Past Medical/Psychological History

NO YES

- ☐ ☐ Tuberculosis:
- ☐ ☐ Diabetes:
- ☐ ☐ Heart or Cardiovascular Disease:
- ☐ ☐ Hypertension:
- ☐ ☐ Cancer:
- ☐ ☐ Kidney Disease:
- ☐ ☐ Allergies: If yes, state: _____

_____

NO YES

- ☐ ☐ Epilepsy or seizure disorder:
- ☐ ☐ Drug alcohol abuse or addiction:
- ☐ ☐ Psychiatric or Behavioral Disorder:

Other: _____

Are you now taking medications?

If so, for what? _____

_____

_____

EXAMINER: PLEASE COMPLETE THE FOLLOWING:

## II. Mandatory Immunizations & Lab tests Exact titre number must be given as requested.

PPD (MANTOUX) Date Given_____ Date Read_____ Results: NEGATIVE_____mm POSITIVE_____mm

WHOLE BLOOD ASSAY TEST FOR T.B. Alternative to PPD testing: Date Drawn:_____ Results:_____ (NEGATIVE/POSITIVE)

CHEST X-RAY (Mandatory only if PPD/blood. Assay is positive) Date:_____ Results:_____

RUBELLA Titre:_____ Date:_____ Results: ☐Immune ☐Not Immune RUBELLA VACCINE_____ IF NEEDED

RUBEOLA *(not needed if born before 1957)* Titre:_____ Date:_____ Results: ☐Immune ☐Not Immune

RUBEOLA VACCINE: 1ST_____ 2ND_____

HEPATITIS B: ☐Immune ☐Refusal ☐Immunization Contraindicated | Vaccine Dates: _____ , _____ , _____

## III. LAB TESTS: URINALYSIS: _____ _____ CBC: _____ _____

## IV. REVIEW OF SYSTEMS BY EXAMINER:

Head/Neck:_____ EENT:_____ Resp. :_____ Cardiovasc.:_____ Abd-GI:_____ GU:_____

Muse–skel:_____ Neuro:_____ Endocrine:_____ Skin:_____ Height:_____ Weight:_____

## V. MEDICAL EXAMINER I hereby certify that the above named patient does not have any limitations for employment in the health care field, and contact with patients and other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

**PHYSICIAN'S SIGNATURE:**_____ PHYSICIAN'S NAME (PRINT)_____

Address:_____ Phone:_____

(PLEASE USE PHYSICIAN'S STAMP)