EMPLOYEE HEALTH FORM

☐ STATEMENT OF SATISFACTORY HEALTH (✓) IF THIS SECTION IS TO BE COMPLETED)

_________________________________ is found to be in good health without evidence of communicable disease and free of work restrictions on this date. Date of last physical exam: _________________________

Date of 1st Mantoux: _______ Results: _______ MM Date: _______ Signature/Title: ______________________

Date of 2nd Mantoux:________ Results: _______ MM Date: _______ Signature/Title: ______________________

(If Positive, need Chest X-Ray & Yearly ProMed TB questionnaire)

Date of Chest X-ray:_________Results: ____

☐ Repeat Chest X-ray required on___/___/___ ☐ Other:__________________________________

☐ Repeat Chest X-ray with development of symptoms

Signed: ______________________________________ Date: _______________________________

Physician or Licensed Nurse Practitioner or PA

☐ EMPLOYEE HEALTH HISTORY (✓) IF THIS SECTION IS TO BE COMPLETED) DATE:_____________

COMPLETED BY: ☐ **SUPERVISING RN** ☐ **PHYSICIAN/LICENSED NURSE PRACTITIONER/PA**

Yes	No		Yes	No		Yes	No		Yes	No	In last 12 months:
☐	☐	Diabetes	☐	☐	Shortness of Breath	☐	☐	Stroke	☐	☐	Hospitalized
☐	☐	Heart Disease	☐	☐	Asthma/Bronchitis	☐	☐	Kidney Disease	☐	☐	Lung disease
☐	☐	Tuberculosis	☐	☐	Epilepsy/seizures	☐	☐	Unexplained Fever	☐	☐	Back/Spinal problems
☐	☐	Hepatitis B	☐	☐	Mental Disorder	Other_______________			______________________		

Do you have any of these conditions or any other conditions which might cause risk to the patient or could potentially interfere with the performance of one's duties, including the habituation of alcohol or current addiction to depressants, stimulates, narcotics, or other substances.

Do any of these conditions impair your ability to perform the essential functions of the job. If "yes" explain/give dates: ______________

	Had Disease			Dates (Month/Year)				Had Disease			Dates(Month/Year)		
Disease	**Yes**	**No**	**Year**	**Titer**	**Results**	**Vaccination**	**Disease**	**Yes**	**No**	**Year**	**Titer**	**Results**	**Vaccination**
Chicken Pox							Mumps						
Measles (Rubeola)							G.Measles (Rubella)						

Employee Signature: ______________________________ **Practitioner Signature/Title:**___________________________

☐ EMPLOYEE HEALTH EXAMINATION RECORD (✓) IF THIS SECTION IS TO BE COMPLETED

Blood Pressure_________ T _________ P_________ R_________ Height:_____ Weight_____

Ears:________________________ Abdomen:_________________ Hernia:_________________________

Eyes:________________________ GU History:_______________ GI History:______________________

Teeth:________________________ Skin:____________________ Extremities:_____________________

Nose & Throat_________________ Scars:___________________ Other:__________________________

Lungs:_______________________ Heart:___________________ ________________________________

Major Illnesses/Operations/Injuries:____

Work Restrictions ☐Yes ☐No If "yes," explain:____

Physical accommodations required to perform essential functions of the job. If applicable explain:

____

____

May safely wear HEPA mask ☐Yes ☐No If "no,"explain:____

____________________________ is found to be in good health without evidence of communicable disease, is free from health impairment which may cause risk to the patient or which might interfere with his or her duty including the habituation of alcohol, addiction to depressants, stimulants, narcotic, or other drugs or substances which may alter your behavior.

Signed: ______________________________________ Date:____

Physician or Licensed Nurse Practitioner or PA

9731 W. 165th Street • Suite 34 • Orland Park, IL • 60467• Phone (708) 349 – 1080 • Fax (708) 349-1590