Tel:646-431-0025/917-639-3419 FAX:347-368-0618
QUEENS HOMECARE AGENCY

EMPLOYMENT PHYSICAL EXAMINATION REPORT

Pre-Employment Physical Assessement [ ]	Annual Assessment [ ]	Return to Work/LOA [ ]	Other:

Name:	Martial Status: M[ ] S[ ] W[ ] D[ ]	Sex: M [ ] F[ ]
Address:	SS#:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:	
EYES:	
NECK:	
BREASTS:	
LUNGS:	
CARDIOVASCULAR:	
MUSCULOSKELETAL:	
ABDOMEN:	
GENITOURINARY:	
CENTRAL NERVOUS SYSTEM:	

COMMENTS:

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

LABORATORY TEST RESULTS MUST BE ACCOMPANIED BY LAB REPORTS

TEST	DATE		RESULTS (Provide Values & Interpretation)
RUBELLA TITER			[ ]Non_Immune [ ] Immune Lab Val:
MEASLES TITER			[ ]Non_Immune [ ] Immune Lab Val:
[ ] PPD (ANNUALLY)	1 Date Implanted	1 Date Read	RESULTS (mm x mm):
PPD (2nd DOSE)	2 Date Implanted	2 Date Read	RESULTS (mm x mm):
[ ] CHEST X-RAY(+PPD)			RESULTS:
[✔] DRUG TEST			COMMENTS:

[ ] Flu Shot Date: MFR: Lot Number:

IMMUNIZATIONS	DATE	DATE	DATE
RUBELLA	1		
RUBEOLA/MEASLES	1	2	
HEPATITIS 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 habtuation or addiction to drugs or alcohol.

[ ] 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. Date:

Queens Homecare Agency

TUBERULOSIS SCREENING

If you have had a previously tuberculosis (TB) test (tuberculin skin test or IGRA [Quantiferon or T-Spot]) it is recommended that you undergo an annual symptom review. A previously positive TB test means that sometime during your life you have been infected with the TB bacteria: it, in and of itself, does not mean that you have Active TB Disease.

Name _____ DOB _____

Have you had any of the following signs or symptoms of TB lasting longer than 2 weeks?

1) History of temporary or permanent residence (for > 1 month) in a country with a high TB (i.e. Any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe); ***Yes NO***
2) Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment, treatment with an TNF - alpha antagonist (e.g., Infliximab, etanercept, or other), chronic steroids (equivalent of prednisone>15mg/day for> 1 month) or other immunosuppressive medication; ***Yes NO***
3) Close Contact with someone who has had TB disease: ***Yes NO***
4) Whether the individual has been treated for latent TB infection; ***Yes NO***
5) Symptom screening:
    - Productive cough for more than 3 weeks; ***Yes NO***
    - Coughing up blood; ***Yes NO***
    - Unexplained weight loss; ***Yes NO***
    - Fever, chills or drenching night sweats for no known reason; ***Yes NO***
    - Persistent shortness of breath; ***Yes NO***
    - Unexplained fatigue for more than 3 weeks; ***Yes NO***
    - Chest pain. ***Yes NO***
6) Question as to prior diagnosis of active TB or latent TB infection or a positive skin test or positive blood test for TB; ***Yes NO***
7) Question as to whether the individual has been treated with medication for TB or for a positive TB test. ***Yes NO***
8) Further action required:

_____

_____

_____

_____ Date _____

Evaluator (print Name)

_____ Date _____

Evaluator Signature

REV 05/2023