

Health Screening Form

TO BE COMPLETED BY PHYSICIAN, PHYSICIANS ASSISTANT, OR NURSE PRACTITIONER ONLY

Today's Date: _____

1. Name _____ D.O.B. _____
2. Present Illness/Complaint/Disabilities, if any: _____

3. Allergies: _____
4. Medicine currently prescribed and reason: _____

5. Has client been exposed to any communicable diseases: Yes _____ No _____
If yes, please specify: _____
6. History of chronic or major illness: _____

7. Operations: _____

8. Hospitalizations: _____

9. Immunizations: Last Tetanus Toxoid _____ Polio _____ Measles _____ Mumps _____
Rubella _____ Other _____

Physical Examination

Code: Satisfactory = S

Unsatisfactory = U

Not Examined = O

Height _____

Weight _____

B/P _____

Pulse _____

Respirations _____

Temperature _____

Patient Name _____ Date _____

General Appearance (including schemata of drug abuse)

Nutrition _____

Head: _____

Ears _____ Hearing: R _____ L _____

Eyes _____ Vision: (without glasses) R _____ L _____

(with glasses) R _____ L _____

Nose _____ Throat _____ Mouth/Teeth _____ Neck/Thyroid _____

Chest _____ Cardiac _____ Abdomen _____ Genitalia _____

Hernia _____ Skin _____ Musculo Skeletal _____ Neurologic _____

Required Blood Tests:

S.T.D. (Syphilis, Gonorrhea,

Chlamydia) _____

Hepatitis Panel:

(A, B, & C) _____

Hep B surface antibody _____

Hep B core antibody IGM _____

Required Tests:

T.B. Test _____
(Wait until you are instructed)

Urinalysis _____

H.I.V. _____

Required Tests (Female):

Pregnancy _____

Pap Smear _____

Attach computer printout of all test results.

*T.B. Results: Must be within 30 days of entry

Optional Tests:

CBC _____ Liver Function _____

General comments, assessments, and recommendations on above:

Signature of examining Physician

Address: _____

City, State, Zip: _____

Phone: _____

DENTAL EXAM: Please Check

Needed work was done Yes No

No further work is needed at this time Yes No

Further work is needed soon Yes No

Dentist Signature

Phone Number