

**Health Screening Form**

**TO BE COMPLETED BY PHYSICIANS 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 \_\_\_\_\_

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**Physical Examination**

Code: Satisfactory = S

Unsatisfactory = U

Not Examined = O

Height \_\_\_\_\_

Weight \_\_\_\_\_

B/P \_\_\_\_\_

Pulse \_\_\_\_\_

Respirations \_\_\_\_\_

Temperature \_\_\_\_\_

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. \_\_\_\_\_

Hepatitis:  
(A, B, & C) \_\_\_\_\_

H.I.V. \_\_\_\_\_

**Required Tests:**

\*T.B. \_\_\_\_\_

Urinalysis \_\_\_\_\_

Dental Exam \_\_\_\_\_

**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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_