***ELEON HEALTHCARE INC.***

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***PHYSICAL EXAMINATION FORM***

**DATE OF EXAM**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRE- EMPLOYMENT ASSESSMENT\_\_\_ ANNUAL ASSESSMENT\_\_\_\_ RETURN TO WORK/LOA\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| NAME OF EMPLOYEE: | SEX: M\_\_\_ F\_\_\_ | SSN: \_ \_ \_-\_ \_-\_ \_ \_ \_ |
| HOME ADDRESS: | DOB : | MARITAL STATUS: S\_ W\_ M\_D\_ |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Height : | Weight: | | BMI: | | Respirations: | Allergies: | |
| Blood Pressure: | | Temp | | Pulse | | | Pulse |

**PHYSICAL EXAMINATION**

|  |  |  |
| --- | --- | --- |
| HEAD: | HEART: | THROAT: |
| EYES: | LUNGS: | THYROID: |
| NOSE: | BREAST: | NODES: |
| EARS: | ABDOMEN: | SKIN: |

**LABORATORY RESULTS**

|  |  |  |  |
| --- | --- | --- | --- |
| **TEST** | **DATE PERFORMED** | **RESULTS** | **LAB VALUE** |
| **RUBELLA TITER** | **----/----/----** |  | **Lab Value:** |
| **MEASLES TITER** | **---/---/----** |  | **Lab Value:** |
| **PPD 1st Step** | **Implanted:** | **Read:** | **Result:** |
| **PPD 2nd Step** | **Implanted:** | **Read:** | **Result:** |
| **CHEST X-RAY** | **Performed:** |  |  |

**Does this patient exhibit any symptoms related to tuberculosis?**

|  |  |  |
| --- | --- | --- |
| YES NO | YES NO | YES NO |
| Chills | Fever | Night Sweats |
| Chronic Cough | Sputum | Weight Loss |

**Summary of Findings:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby certify that I have examined this individual and the above is a complete and accurate record of my examination.**

**I hereby state that this employee is in good physical and mental health, which is required to perform the essential functions of a home health care employee.**

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lic. No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_