ANNUAL PHYSICAL EXAM

NAME _____ DATE OF EXAM _____

ADDRESS _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____ SEX _____ BP _____

LABORATORY RESULTS

TB TEST-PPD/Quantiferon
DATE ADMINISTERED _____ READ _____ RESULTS _____

2ND STEP PPD
DATE ADMINISTERED _____ READ _____ RESULTS _____

CHEST X-RAY (IF POSITIVE PPD)
DATE _____ RESULTS _____

RUBELLA TITER
IMMUNIZATION DATE _____ RESULTS _____

RUBEOLLA TITER
IMMUNIZATION DATE _____ RESULTS _____

MUMPS TITER
IMMUNIZATION DATE _____ RESULTS _____

VARICELLA TITER
IMMUNIZATION DATE _____ RESULTS _____

TETANUS
IMMUNIZATION DATE _____

DIPHTERIA
IMMUNIZATION DATE _____

POLIO
IMMUNIZATION DATE _____

HEPATITIS B SCREENING
VACCINE DATE 1 _____ VACCINE DATE 2 _____ VACCINE DATE 3 _____

FLU SHOT
DATE ADMINISTERED _____

I certify that the named individual was examined by me and is found to be in optimal health, is free from any communicable diseases and is free from habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior. Is able perform the required duties as a Healthcare Clinician.

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S NAME _____ PHONE NUMBER _____

PHYSICIAN'S STAMP _____ LICENSE # _____

REHAB ALTERNATIVES

ANNUAL TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

EMPLOYEE NAME

EMPLOYEE SIGNATURE

TODAY'S DATE

1. Have you ever had a Tuberculosis test? ☐ YES ☐ NO
   a. PPD Mantoux Date(s): Results:
   b. Chest X-Ray Date: Results:
   c. Treatment Type: Results:

2. Do you currently have any of the following symptoms?

Symptoms	Yes	No	Comments
WEAKNESS			
FATIGUE			
LOSS OF APPETITE			
LOW GRADE FEVER			
WEIGHT LOSS			
NIGHT SWEATS			
FLU-LIKE SYMPTOMS			
CHEST PAIN			
SHORTNESS OF BREATH			
PERSISTENT COUGH			
BLOOD-STREAKED SPUTUM			
COLOR OF SPUTUM	Clear	Yellow	Other (Please Describe)

3. Have you ever been exposed to anyone exhibiting the above symptoms or someone who has had active tuberculosis? ☐ YES ☐ NO

THIS SECTION TO BE COMPLETED BY HEALTHCARE PROVIDER (SCREENER) ONLY
(PA, NP, RN, LPN under RN supervision, PharmD)

HEALTHCARE PROVIDER SIGNATURE

HEALTHCARE PROVIDER LICENSE #

TODAY'S DATE