Unlimited Care, Inc.
HEALTH CARE SERVICES

EMPLOYEE HEALTH EXAMINATION RECORD

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ TEL: _____

I have read this form and declare that I have no injury, illness or ailment other than specifically noted herein. Any falsification or misrepresentation will be sufficient grounds for my release from employment.	Applicant Signature _____ Date _____

EMPLOYEE TO ANSWER: (NOTE DETAILS FOR ANY 'YES' ANSWER)

	YES	NO		YES	NO		YES	NO		YES	NO
OPERATIONS	☐	☐	CHR.BACK PAIN	☐	☐	MENTAL DISEASE	☐	☐	SKIN DISEASE	☐	☐
FRACTURES	☐	☐	TUBERCULOSIS	☐	☐	JAUNDICE	☐	☐	HYPERTENSION	☐	☐
HEAD INJURY	☐	☐	FAINTING SPELLS	☐	☐	RHEUMATISM	☐	☐	HEART TROUBLE	☐	☐
BACK INJURY	☐	☐	EPILEPSY	☐	☐	SINUS TROUBLE	☐	☐	STOMACH TROUBLE	☐	☐
									DIABETES	☐	☐

DETAILS: _____

TB SCREENING:

UNEXPLAINED FEVER?	☐YES	☐NO	LOSS OF APPETITE?	☐YES	☐NO	CLOSE CONTACT WITH A PERSON TESTING POSITIVE FOR TB?	☐YES ☐NO
WEIGHT LOSS?	☐YES	☐NO	FATIGUE/CHILLS?	☐YES	☐NO		
PERSISTENT COUGH?	☐YES	☐NO	SPITTING UP BLOOD?	☐YES	☐NO	SHORTNESS OF BREATH?	☐YES ☐NO
CHEST PAIN	☐YES	☐NO	NIGHT SWEATS?	☐YES	☐NO		

IS THERE A HISTORY OF HABITUATION OR ADDICTION TO DEPRESSANTS, STIMULANTS, NARCOTICS, ALCOHOL OR DRUG OR OTHER SUBSTANCES THAT MAY ALTER INDIVIDUAL'S BEHAVIOR? ☐ YES ☐ NO

PHYSICIAN TO COMPLETE:

BP _____ HT _____ WT _____

RUBELLA TITRE: POS _____ NEG _____ TITRE _____ IF NEGATIVE: 1ST MMR VACCINATION DATE: _____

RUBEOLA TITRE: POS _____ NEG _____ TITRE _____ (D.O.B: 01/01/57 & later) 2ND MMR VACCINATION DATE: _____

MUMPS TITRE (If required) : POS _____ NEG _____ TITRE _____ (D.O.B: 01/01/57 & later) 1st MMR: _____ 2nd MMR: _____

VARICELLA (If required): POS _____ NEG _____ TITRE _____ 1st DOSE: _____ 2nd DOSE: _____

SYSTEM REVIEW:

EARS: _____

EYES: _____

TEETH: _____

NOSE/THROAT: _____

SKIN: _____

HEART: _____

LUNGS: _____

ABDOMEN: _____

HERNIA: _____

EXTREMITIES: _____

ALLERGIES: _____

OTHER: _____

DRUG SCREEN REQUIRED? ☐ YES ☐ NO

P.P.D.#1 DATE PLANTED _____ DATE READ _____

RESULTS: ☐ POS ☐ NEG INDURATION _____ MM

P.P.D #2 DATE PLANTED _____ DATE READ _____

RESULTS: ☐ POS ☐ NEG INDURATION _____ MM

IF APPLICABLE: **CXR** DATE: _____ ☐ POS ☐ NEG

I HAVE COMPLETED AN EXAMINATION OF THE ABOVE INDIVIDUAL AND HAVE FOUND THAT HE/SHE IS CAPABLE OF PERFORMING HOME CARE DUTIES SUCH AS (BUT NOT LIMITED TO) BENDING, LIFTING ASSISTING WITH PERSONAL CARE, PATIENT TRANSFERS, HOUSEKEEPING, LAUNDRY, AND SHOPPING.

PRINT PHYSICIAN'S NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

SIGNATURE: _____

LICENSE NUMBER: _____ DATE: _____