Hamilton Davis Home Care, Inc.

Employee Physical

Name:_____Date:_____
Address: _____
City: _____ State:_____Zip Code: _____
Date of Birth:_____/_____/ _____
Home Phone: (_____)_____- _____
Last four of Social Security No: _____
Emergency Contact:
Name: _____
Address: _____
City:_____ State:_____Zip Code: _____
Home Phone Number: (_____)_____- _____
Cell Number: (_____)_____- _____
Work Number: (_____)_____- _____

Have you had any of the following:

	Yes	No		Yes	No
Operations	_____	_____	Fainting Spell	_____	_____
Fracture	_____	_____	Epilepsy	_____	_____
Head Injury	_____	_____	Mental Disease	_____	_____
Back Injury	_____	_____	Jaundice	_____	_____
Chronic Back Pain	_____	_____	Rheumatism	_____	_____
Tuberculosis	_____	_____	Asthma	_____	_____
Heart Trouble	_____	_____	Sinus Trouble	_____	_____
High Blood Pressure	_____	_____	Skin Disease	_____	_____
Hernia	_____		Menstrual Disorders	_____	_____

Ht:_____Wt:_____BP: _____ P:_____ R:_____ Temp: _____

I have read the above and declare that is true to the best of my knowledge. Any falsification or misrepresentation will be sufficient grounds for my release from employment.

Employee Signature: _____

Passed Exam:_____ Failed Exam: _____
If Failed reason:

_____

_____

I have reviewed the above and examined patient and find no evidence of communicable diseases.

RN Name (Please Print): _____

RN Signature: _____

2001 Airport Road • Suite 305 • Flowood, Mississippi 39232 • Office: (601) 932-1003 • Fax: (601) 932-1007 • www.hamiltondavishomecare.com

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Employee Physical

Name:_____ Date:_____

1. General Appearance and Personal Hygiene	2. Height	3. Weight	4. Temperature (oral)
5. Blood Pressure	6. Pulse	7. Gail	

8. Deformities ☐ NO ☐ YES	16. Lungs ☐ WNL ☐ ABN	24. Tremor ☐ NO ☐ YES
9. Skin ☐ WNL ☐ ABN	17. Heart ☐ WNL ☐ ABN	25. Extremities ☐ WNL ☐ ABN
10. Eyes ☐ WNL ☐ ABN	18. Abdomen ☐ WNL ☐ ABN	26. Varicosities ☐ NO ☐ YES
11. Ears ☐ WNL ☐ ABN	19. Hernia ☐ NO ☐ YES	27. Back ☐ NO ☐ YES
12. Nose ☐ WNL ☐ ABN	20. Genitalia ☐ WNL ☐ ABN	28. Enlarges Nodes ☐ WNL ☐ ABN
13. Mouth &Throat ☐ WNL ☐ ABN	21. Varicosities ☐ NO ☐ YES	29. Rectal Exam (Optional) ☐ NO ☐ YES
14. Head, Neck ☐ WNL ☐ ABN	22. Hydrocele ☐ NO ☐ YES	30. Nervous and Mental Status ☐ NO ☐ YES
15. Chest ☐ WNL ☐ ABN	23. Reflexes ☐ WNL ☐ ABN	31. EKG ☐ WNL ☐ ABN

REMARKS:

_____

_____

_____

LABORATORY

Urine SP. GR.	Albumin	Sugar	Microscopic	Chemistry ☐ See attached

Audio gram ☐ NORMAL ☐ ABNORMAL	CBC ☐ see attached
Chest X-Ray ☐ NORMAL ☐ ABNORMAL	Pulmonary Function ☐ NORMAL ☐ ABNORMAL (see report)
Spine X-Ray ☐ NORMAL ☐ ABNORMAL	

A. Employment Without Restrictions
B. Employment With Recommendations
C. Unclassified Pending Further Evaluation
D. Rejection Until Defect is Corrected
E. Rejection
F. Please call for Discussion

CLEARED FOR RESPIRATOR USE YES ☐ NO ☐

MUST WEAR GLASSED OR CONTACTS YES ☐ NO ☐

To the best of my Knowledge this employee is free from communicable or infectious disease. This employee may have a TB skin test (PPD) and the Hepatitis Vaccine upon consent.

Medical Examiner: _____

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