**Date:** _____

**Name:** _____ _____
**(Last Name)** **(First Name)**

**Address:** _____
**Street Name** **Apt. No.**

_____
**City** **State** **Zip Code**

**Hone Phone #:** _____ **Cell Phone #:**_____

**Date of Birth:** _____ **Sex:** _____ **SS#:** _____

Name and phone number of a person to call in case of an emergency.

**Name:** _____

**Address:** _____

_____

**Phone #:** _____

**Relationship:** _____

**Personal Physician Name:** _____

**Physician Phone #:** _____

## MEDICAL HISTORY

**If you ever had or been told that you have had any of the following, please check all that apply below:**

☐ Asthma, Bronchitis, Pneumonia or Emphysema
☐ Heart Disease of Heart Attack
☐ Stroke or High Blood Pressure
☐ Diabetes [high blood sugar]
☐ Hypoglycemia [low blood sugar]
☐ Kidney Disease or Bladder Infections
☐ Vision Problems [Glaucoma, cataracts, color blindness, etc…)

☐ Back Injuries or Problems
☐ Hearing Problems
☐ Any Skin Conditions
☐ Cancer
☐ Epilepsy
☐ Depression or Anxiety
☐ Arthritis
☐ Autoimmune Disease [Lupus, rheumatoid arthritis]

**MEDICAL HISTORY CONT…**

**NAME:** _____

Do you have any other medical conditions we should be aware of in case of a medical emergency? If so, record here:

_____

_____

Do you take any medications? If so, please here including over the counter medications and vitamins.

| Medications | Dosage | Frequency | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you had any surgeries in the past? If so, please indicate here (inpatient and outpatient)

| Surgery | Hospital | Date (s) |
|---|---|---|
| | | |
| | | |

Have you had any surgeries in the past? If so, please indicate here (inpatient and outpatient)

| Reason | Hospital | Date (s) |
|---|---|---|
| | | |
| | | |
| | | |

Please list health immunization history below

| Vaccine | Date of Immunization | Date of Titer & Result | Verification/Source |
|---|---|---|---|
| Measles # 1 | | | |
| Measles # | | | |
| Rubella | | | |
| Last Tetanus | | | |
| Other | | | |

**To be Read and Signed by Applicant:**

I certify that I have disclosed all known current health conditions or problems that may pose a potential risk to others or which may interfere with the performance of my duties/or services. I am not habituated or addicted to narcotics, depressants, stimulants, alcohol or other drugs/substances which may affect or alter my behavior. I clearly understand that my failure to disclose requested medical information or giving inaccurate or misleading answers would be sufficient cause for my termination.

Signature: _____ Date: _____

alliance services FOR TBI, INC.

# POSITIVE PPD/TB SIGNS AND SYMPTOMS QUESTIONNAIRE

**NAME:** _____

Please complete this form and answer the following questions before you have the PPD Test.

Have you experienced any of the following symptoms, please check if yes:

| **Symptoms** | **Yes** | **No** | **Please Clarify** |
|---|---|---|---|
| Unexplained Productive Cough/persistent cough | | | |
| Unexplained Weight Loss | | | |
| Fatigue | | | |
| Loss of Appetite | | | |
| Night Sweats | | | |
| Shortness of Breath | | | |
| Chest Pains | | | |
| Low Grade Fever | | | |
| Allergies | | | |
| Blood Streaked Sputum | | | |
| **Have you had:** | | | |
| A vaccination of any kind in the last 3-6 months | | | |
| **Have you ever:** | | | |
| Been informed that you have TB | | | |
| Come in contact/live with anyone with TB | | | |
| Had a positive TB test | | | |
| Received the BCG Vaccine | | | |

If you experience any of the symptoms listed above, please consult with your physician as soon as possible for reevaluation and notify your interviewer or a human resource personnel immediately. Further, if applicant has a history of PPD Positive, he/she must provide current Chest X-Ray (shall be within 1 year) result to the agency. The applicant will not be allowed to begin employment until such result is provided.

Signature: _____ Date: _____

**PART II: TO BE COMPLETED BY MEDICAL DOCTOR**

Name: _____ Date of Examination_____

Age: _____ Height: _____ Weight: _____lbs. Allergies: _____

Blood Pressure: _____ Pulse: _____ Respiration: _____

If they are any deviations, please give details below:

| | Normal | Abnormal | Please Specify |
|---|---|---|---|
| Skin | | | |
| Neck | | | |
| Eyes | | | |
| Ears | | | |
| Nose | | | |
| Mouth & Throat | | | |
| Thyroid | | | |
| Lymph | | | |
| Heart | | | |
| Chest | | | |
| Abdomen | | | |
| Extremities & Pulses | | | |
| Neuro. | | | |
| Spine: motion etc… | | | |

Remarks:

_____

_____

_____

_____

**Referred to**: _____

On the basis of the limited exam I performed on the above individual, as well as information he/she provided, it is my opinion that this individual is free from a health impairment which is of potential risks to the consumers he/she will work with or which might interfere with the performance of his/her duties.

MD Name: _____ Date: _____
Print Name

MD Signature: _____ License #: _____

**Cleared to commence employment: _____**
**Not cleared (please state reason):_____**

**PART III: TO BE COMPLETED BY MEDICAL DOCTOR**

**TUBERCULIN SKIN TEST/ PPD/MANTOUX TEST READING**

In compliance with CDC/DOH Recommendations and Alliance Services for TBI policy, the TST should be read by a RN, NP, PA or MD. **Self reading of the Tests ARE NOT ACCETABLE**.

---

**This Section is to be completed by the Administering Clinician**

**APPLICANT NAME:** _____
**(Please Print)**

**Social Security #:** _____

Reason for Test:
Pre-Employment _____
Routine _____
TB Contact- 1st _____
TB Contact-f/u _____

Date of TST Test: _____ Arm Location: ☐ Right Arm ☐ Left Arm

Lot No: _____ Brand: _____ Expiration Date: _____

Administered by: _____ _____ _____
Please Print Signature Title

---

**This Section is to be completed by the Reader**

Induration (not erythema) along the transverse axis of the foreman must be measured and documented appropriately. If Tuberculin Skin Test is positive, individual must have Chest X-Ray done and provide result of the X-Ray to the Agency.

**Date of Test Reading**: _____

**Results of Reading**: **Negative:** _____ mm induration (must be documented in mm)

**Positive:** _____ mm

Read By: _____ _____ _____
Please Print Signature Title

---

If this Tuberculin Skin Test is not completed, **you WILL NOT** be medically cleared for employment purposes or your annual health assessment will be incomplete. If you are currently employed with Alliance Services for TBI, you will be taken off duty until this requirement is satisfied.