TODAY'S HOMECARE, INC.
ENJOY TODAY & CREATE A BETTER TOMORROW

TODAY'S HOMECARE, INC.
www.TodaysHC.com

PHYSICAL EXAMINATION

Last Name: _____ **First Name:** _____

ADDRESS: _____

PHONE: _____ CELL PHONE**:** _____

I. Past Medical/Psychological History

CONDITION	YES	NO	CONDITION	YES	NO
Tuberculosis			Kidney Disease		
Diabetes			Allergies (if yes, state)		
Heart or Cardiovascular Disease			Epilepsy or seizure disorder		
Hypertension			Drug alcohol abuse or addiction		
Cancer			other		

Are you now taking medications? If so, please list: _____

II**. Mandatory** Immunizations and Lab tests. **Exact titre number must be given as requested**.

PPD (MANTOUX) DATE GIVEN: _____ DATE READ: _____
RESULTS: NEGATIVE: _____mm POSITIVE: _____mm
2nd STEP PPD DATE GIVEN: _____DATE READ: _____
RESULTS: NEGATIVE: _____mm POSITIVE: _____mm

Alternative to PPD testing: WHOLE BLOOD ASSAY TEST FOR T.B.
DATE DRAWN: _____RESULTS: _____ (NEGATIVE/POSITIVE)

CHEST X-RAY (MANDATORY ***ONLY*** IF PPD/blood assay IS POSITIVE) DATE: _____ RESULTS: _____

III.

RUBELLA: TITRE_____ IMMUNE ☐ NOT IMMUNE ☐	RUBEOLA (not needed before 1957): TITRE _____ IMMUNE: ☐ ; NOT IMMUNE: ☐
RUBELLA VACCINE (if needed) _____	RUBEOLA VACCINE: 1_____ 2_____
VARICELLA IGG TITRE:	RESULTS: _____ ☐ IMMUNE ☐ NOT IMMUNE
DRUG SCREEN: DATE: _____ RESULT_____ (please attach lab)	

IV. REVIEW OF SYSTEMS BY EXAMINER:

HEAD/NECK		MUSC-SKEL	
EENT		NEURO	
RESP		ENDOCRINE	
CARDIOVASC		SKIN	
ABD-GI		GU	
HEIGHT		WEIGHT	

V. MEDICAL EXAMINER:

I hereby certify that the above-named patient does not have any limitations for employment in the health care field and contact with patients and other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

PHYSICIAN'S NAME (PRINT): _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

ADDRESS: _____ PHONE: _____

(PLEASE USE PHYSICIAN'S STAMP)

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TUBERCULOSIS QUESTIONNAIRE

1. Have you ever had a PPD/Mantoux TB skin test before? Yes: ☐ No: ☐

   If yes, when? _____Result: _____

2. When was your last chest x-ray? Date: _____Results: _____

3. Where were you born? (Country/State): _____

   Were you given BCG? Yes: ☐ No: ☐ I don't know: ☐

   If yes, when? _____

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History of having had a BCG vaccination, exempts you from taking the PPD/Mantoux type TB test ONLY if you have received the BCG within the last five years or you can DOCUMENT the date or a positive (+) PPD test.

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4. Has anyone in your family, any of your friends, or any of your patients had TB? Yes: ☐ No: ☐
   If yes, explain: (If it was a patient, include their name and your dates of care for them).

   _____

   _____

   _____

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

Weakness	Yes_____	No_____
Fatigue	Yes_____	No_____
Lack of Appetite	Yes_____	No_____
Weight Loss	Yes_____	No_____
Low Grade Fever	Yes_____	No_____
Night Sweats	Yes_____	No_____
Flu Like Symptoms	Yes_____	No_____
Chest Pain	Yes_____	No_____
Shortness of Breath	Yes_____	No_____
Persistent Cough	Yes_____	No_____
Blood Streaked Sputum	Yes_____	No_____
Clear, Yellow or Dark Sputum	Yes_____	No_____

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Print Last Name: _____First Name: _____

Employee Signature: _____ ID#: _____Date: _____/_____/_____

MAKE SURE THAT YOU HAVE FILLED IN ALL BLANKS AND SIGNED YOUR NAME

Attention Doctors:

It is our company policy that all individuals employed in our company have an annual complete physical. Complete physicals are to include the following:

- 2 Step PPD, unless Quantiferon TB Gold is provided. (If positive, a copy of Chest X-ray result)
- Rubella, Rubeola and Varicella IGG - Titers
- Drug Screen (urine toxicology screen)

Please note that we need copies of **ALL LAB WORK/REPORTS.**
All paperwork **must** include **DOCTOR'S SIGNATURE & STAMP.**

Sincerely,
HR Department