NoLimits NYC Home Care **EMPLOYMENT PHYSICAL EXAMINATION REPORT**

☐ Pre-Employment Physical Assessment ☐ Annual Assessment ☐ Return to work/LOA ☐ Other:

Name:	Marital Status: ☐M ☐S ☐W ☐D	Sex: ☐ M ☐F
Address:	SS#:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:	HEART DISEASE:	__ YES __ NO
EYES:	HIGH BLOOD PRESSURE:	__ YES __ NO
NECK:	BACK PROBLEM:	__ YES __ NO
BREASTS:	ARTHRITIS:	__ YES __ NO
LUNGS:	PSYCHIATRIC ILLNESS:	__ YES __ NO
CARDIOVASCULAR:	ALCOHOL ABUSE:	__ YES __ NO
MUSCULARSKELETAL:	DRUG ABUSE:	__ YES __ NO
ABDOMEN:	EPILEPSY/SEIZURES:	__ YES __ NO
GENITOURINARY:	ALLERGIES:	__ YES __ NO
CENTRAL NERVOUS SYSTEM:	ASTHMA:	__ YES __ NO

COMMENTS:

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS

TEST	DATE PERFORMED		RESULTS PROVIDE LAB VALUES AND INTERPRETATIONS
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ	RESULTS (mmxmm)
PPD 2ND DOSE	2. DATE IMPLANTED	2. DATE READ	RESULTS (mmxmm)
CHEST X-RAY (FOR +PPD ONLY)	DATE:		RESULTS:

IMMUNIZATIONS:	DATE	DATE	DATE &/or RESULTS
MEASLES/RUBEOLA:	1.	2.	☐ NON-IMMUNE ☐ IMMUNE LAB VALUE:
RUBELLA:	1.	2.	☐ NON-IMMUNE ☐ IMMUNE LAB VALUE:
DRUG SCREEN:	1.	2.	COMMENTS:
HEPATITITS B VACCINE:	1.	2.	3.

☐ This individual is free from any health impairment that is a potential risk to the patient or to other employee or which may interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol.

☐ This individual is able to work with the following limitations**:**

☐ This individual is not physically/mentally able to work. *(specify reason):*

Physician Signature: Lic. No. Date: