

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:
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LABORATORY TEST RESULTS

TEST		DATE PERFORMED		RESULTS PROVIDE LAB VALUES AND INTERPRETATIONS	
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ	RESULTS (mmxmm)		
PPD 2 ND 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:		
HEPATITIS 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:
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